THE BRIDGE TO RECOVERY

1745 The Bridge Road, Bowling Green, KY 42101
* Toll Free 877-866-8661 Fax 270-777-1676 *
www.thebridgetorecovery.com

Consent for Release of Confidential Information

RE: _____ _____
(CLIENT NAME) (DOB)

_____
(ADDRESS) (SOCIAL SECURITY NUMBER)

I, _____, born on _____do hereby authorize the exchange of information between The Bridge to Recovery to: __ Disclose to __ Obtain from In this form: __Electronic __ Verbal __Written
Name_____ Relationship to Client_____
Phone_____ Email_____
Address_____

The Following Information:

(Initial all that applies)

- □ **Medication Information**
- □ **Emergency Contact**
- □ **Family Weekend Information**
- □ **Presence in Treatment / Extension Information**
- □ **Aftercare / Discharge Information**
- □ **Progress in Treatment for Family & Support Team Members**
- □ **Case Consultation w/ Clinical Team Members and Family & Support Team Members**
- □ **Case Consultation w/ Professional Support Team**
- □ **Thanks for referral**
- □ **Financial information**

- □ **Prognosis/Clinical Case Consultation and progress updates with Mental Health Professional**
- □ **Discharge Summary for Mental Health Professionals**

- □ **Other (Explain)**

_____

_____

- □ **Other (Explain)**

_____

_____

Reason for Release of Information:

(Under the Mental Health Code, release of mental health records must be germane to the purpose and need for disclosure.)

- □ **Emergency contact**
- □ **Client Support**
- □ **Referent Relations**
- □ **Continuity of Clinical Treatment – Client History – Case Management Services**
- □ **Court Services – Legal purposes – Probation – Disability Claiming – Unemployment Claiming – Employment**
- □ **Finances**
- □ **Other (Explain) _____**

I understand that my records are protected under Federal Confidentiality regulations (42 CFR Part 2) published August 10, 1987, and the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. Seq and cannot be disclosed without my written consent. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions. I understand that I may revoke this authorization at any time upon verbal and/or written notice. I acknowledge that such revocation will not be effective if The Bridge to Recovery has already acted in reliance upon this authorization. This authorization is valid (if not previously revoked) this consent will terminate upon 365 days from the date of signature of this form, or the following event/condition: _____, or the completion of treatment, or at the time of the final insurance billing, as the case may be, whichever is later.

Prohibition on Re-disclosure

This information has been disclosed from records protected by Federal Confidentiality rules (42 CFR part 2). The Federal rules prohibit making any further disclosure of this information per Federal Guidelines of 42 CFR part 2. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

_____ _____ _____ _____
(CLIENT SIGNATURE) (DATE) (WITNESS/STAFF SIGNATURE) (DATE)

In order for records to be sent out, there is a standard fee of .50/per page:

□ By Checking this box, I am agreeing to the terms and conditions of requesting my records from TBR including my acknowledgement that I am responsible for the payment of .50/per page. That my record request will not be sent out until payment has been made to TBR.