

COMMUNITY ASSESSMENT, REFERRAL & EDUCATION (CARE)
CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

1. I, _____, authorize **CARE's WorkLife Solutions**

to disclose to _____
(Name of person or organizations to which disclosure is to be made)

The following information: **Confirmation of appointments, confirmation of assessment/referral, acceptance of recommendations, and/or** _____.

The purpose of the disclosure authorized herein is: **per client's request to comply with employer's request.**

I further authorize _____
(Name of person or organization making disclosure)

to release to **CARE's WorkLife Solutions** (Name of person or organization to which disclosure is to be made)

the following information: **Reason for referral, specific back-to-work stipulations, if any.**

The purpose of the disclosure is: **per client's request to assist with determination of treatment needs.**

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45CFR Pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

6 Months after either notification of failure to enter treatment or confirmation of discharge _____

(Specification of the date, event or condition upon which this consent will expire)

Dated: _____

(Signature of Client)

(Signature of parent, guardian or authorized representative when required)

A photocopy/facsimile of the signed consent shall have the same force and effect as the client's original signature.