CARE of Southeastern Michigan
CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____ authorize
** *(Student Name)*

CARE or Southeastern Michigan / Student Assistance to disclose to

_____
***(school which disclosure is to be made)*

The following information: **Confirmation of CARE appointments, confirmation of assessment, acceptance of recommendations for treatment/education/self-help, level of care referred to, rationale for referral, treatment agency referred to, confirmation of treatment appointments and/or**

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

I further authorize _____
** *(school making disclosure)*

to release to **CARE of Southeastern Michigan / Student Assistance**

the following information: **Reason for referral, specific back-to-school or court stipulations, if any, and/or drug testing results, 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 CRF 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 understand that the program may not condition treatment on whether I sign this authorization, unless otherwise allowed by law. I am entitled to receive a copy of this authorization after it is signed. 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)

Date: _____ _____
(Signature of Student)

_____
(Signature of Parent, Guardian or authorized representative when required)

CARE OF SOUTHEASTERN MICHIGAN

Please fax this release to: 586-541-2274

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