AREA SUBSTANCE ABUSE COUNCIL
CONSENT TO RELEASE/OBTAIN INFORMATION

I, _____, DOB ___/___/___, authorize release of information as
(Client name – please print)
as indicated below between the Area Substance Abuse Council (ASAC) and:

_____ Insurance Company
Name or Title of Person or Organization — Relationship
Or their Contracted Review Agency

_____ ( )

_____
City State Zip Code

To be released from ASAC

YES	Presence in facility/program involvement and attendance
YES	Treatment progress/summary
YES	ASAM/Evaluation/Assessment information
YES	Medical information
YES	Entire treatment file
YES	Alcohol and other drug use history
YES	Discharge information
YES	Drug/Alcohol screening results
NO	Psychological/Psychiatric history
NO	Other (specify) _____

_____

The only purpose(s) for the disclosure of the above information is:

NO	Facilitate significant other's involvement in patient's treatment
NO	Collaboration of the patient's substance abuse history and behavior
YES	Coordination of treatment services
NO	Communication regarding legal matters
YES	Determine eligibility for insurance benefits and subsequent billing.
NO	Other (specify) _____

_____

To be released to ASAC

NO	Program involvement
NO	Treatment progress/summary
NO	ASAM/Evaluation/Assessment information
NO	Medical information
NO	Entire treatment file
NO	Alcohol and other drug use history
NO	Discharge information
NO	Drug/Alcohol screening results
NO	Psychological/Psychiatric testing and history
YES	Other (specify) Insurance benefits and authorization for treatment.

_____

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NO	Collaboration of the patient's substance abuse history and behavior
YES	Coordination of treatment services
NO	Communication regarding legal matters
YES	Determine eligibility for insurance benefits and subsequent billing.
NO	Other (specify) _____

_____

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient records, 42 C.F.R. Part 2, 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 six (6) months after last service or as follows:

Until all ASAC financial matters have been resolved
(Specification of the date, event, or condition upon which this consent expires instead of six months after last service)

_____ _____
Client signature Witness Signature & Title

_____ _____
Date Date