TELLURIAN U.C.A.N., INC.

Authorization For Release of Confidential Information

1. Client/Patient Information

Name: _____

Address: _____

Phone Number: _____Date of Birth: _____ Social Security #: _____

2. Information to be disclosed:

___Comprehensive overview of entire chart (contains all assessment and discharge paperwork and summaries, social history, treatment plans, progress notes, incident reports, and unit specific documentation)

___Records pertaining to: _____

date(s) or condition(s)

Specific information: (please check appropriate lines)

___Legal information

___AODA/Mental Health treatment records

___Progress in treatment/progress notes

___Discharge summary & Plan

___ Psychiatric/Psychological evaluation

___ Medication & Medical History

___Assessment, History diagnosis

___Other (please specify: _____)

For services received from _____ to _____(dates of service if known).

Disclosed By:

_____

Name of Program

_____

Address

_____

Phone number

_____

FAX number

Disclosed To:

_____

The Purpose or need for this disclosure is:

___Continuity of care

___Monitor compliance with legal matters

___Consultation

___Other please specify:_____

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Mental Health, Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 45 C.F.R. pts. 160& 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. If not previously revoked, this consent will be automatically terminated in one (1) year from the date of signature. This consent will also expire automatically as follows:

_____

(specification of the date, event, or condition upon which this consent expires)

Generally, I am not required to sign this form in order to receive services at Tellurian, however, there are certain circumstances permitted under applicable law where treatment may be denied unless there is a signed release.

_____

Signature of patient or guardian **Date signed**

_____

Signature of witness **Date signed**

____ I want a copy of this release form ___ I do not want a copy of this release form

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Tellurian UCAN, Inc. Corporate Office, 300 Femrite Dr., Monona, WI 53716-3716

File: Section 9, patient (if requested)
Last updated: 3/3/04

1-608-222-7311 toll free 1-877-661-9051 www.tellurian @ tellurian.org

I hereby revoke this authorization for release of information:

_____

Signature of patient or guardian