CORRESPONDENCE REQUEST FORM

FOR COMPLETION LETTER OR PROGRESS REPORT

TODAY'S DATE: _____

YOUR NAME: _____ **DATE OF BIRTH**: _____

In order to receive a Completion Letter or Progress Letter you must have a ZERO balance.

RECIPIENT'S NAME: _____

- ☐ Lawyer
- ☐ Probation Officer
- ☐ Employer
- ☐ School

PHONE: _____

FAX/ EMAIL:_____

MUST BE FILLED OUT, OR REQUEST IS NOT SUBMITTED

PURPOSE OF LETTER (Check one):

☐ Progress Letter ☐ Completion Letter

Date Needed: _____

- ☐ No charge (6-10 Business Days from request)
- ☐ $50 Fee (1-5 Business Days)
- ☐ $75 Fee (Same Day)

TURN OVER

FILL OUT BACK
THIS IS A TWO-SIDED FORM

Consent for the Release of Confidential Information

NAME:_____

(Circle One: Spouse, Parent, Attorney, Probation Officer, Counselor, Physician, Other/Please State)

PLEASE ENTER ONLY ONE NAME ABOVE; A <u>SEPARATE FORM</u> MUST BE COMPLETED FOR EACH PERSON TO WHOM YOU ARE ALLOWING INFORMATION TO BE RELEASED

<u>FULL RELEASE</u>

☐ I authorize the Columbia Addictions Center, LLC, doing business as Columbia Treatment Center (CTC) to release information to, and to obtain information from, the person or organization I have written above.

-OR-

<u>LIMITED RELEASE</u>

☐ I authorize the CTC to release ***only*** the following information to the person or organization I have written above:

_____Appointment Dates/Times

_____Account Balance

_____Initial Evaluation

_____Progress, Attendance, Completion and Discharge Reports

_____Urinalysis or Breathalyzer Results

Signed by: _____ _____

Signature of Patient or Legal Guardian Relationship to Patient

_____ _____

Print Patient's Name Date

This authorization will be valid for one year unless I otherwise specify.

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization.