

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**

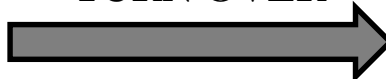
PURPOSE OF LETTER (Check one):

- 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 SEPARATE FORM MUST BE
COMPLETED FOR EACH PERSON TO WHOM YOU ARE ALLOWING INFORMATION
TO BE RELEASED**

FULL RELEASE

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-

LIMITED RELEASE

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.