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

PHONE: _____

FAX:_____

FULL RELEASE

☐ I authorize Columbia Treatment Center to release information to, and to obtain information from, the person or organization I have written above.

-OR-

LIMITED RELEASE

☐ I authorize Columbia Treatment Center 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.

Columbia Addictions Center, LLC DBA
Columbia Treatment Center
5570 Sterrett Place, Suite 205, Columbia, MD 21044
Tele: 410.730.1333 Fax: 410.730.1559 Email: ctc@columbia-treatment.com