THE RIGHT STEP, INC.

I, _____ authorize staff members employed by
(Name of Client and Date of Birth)

The Right Step, Inc. to disclose or exchange information with the following person or organization:

_____
(Name of person or organization to which disclosure is to be made)

Indicate the nature of the information being authorized to be disclosed or exchanged and purpose of consent by marking yes or no for each item

☐Yes or ☐No Client Identifying Information
☐Yes or ☐No Diagnosis, Date(s) of Service
☐Yes or ☐No Recommendations
☐Yes or ☐No Laboratory Reports
☐Yes or ☐No Biopsychological Summary
☐Yes or ☐No Admission to Services
☐Yes or ☐No Treatment plans
☐Yes or ☐No General Progress/Compliance
☐Yes or ☐No After-care Plan/Discharge Summary
☐Yes or ☐No Progress Notes
☐Yes or ☐No Legal Information
☐Yes or ☐No Police Report (REQUEST ONLY)
☐Yes or ☐No Driving Abstract/Defendant Case History (REQUEST ONLY)
☐Yes or ☐No Consultation Information
☐Yes or ☐No Academic Information
☐Yes or ☐No Medical Staff Orders
☐Yes or ☐No Psychiatric/Psychological Evaluations
☐Yes or ☐No Medical History/Physical Exam Results
☐Yes or ☐No Family Program Information
☐Yes or ☐No Clearly specify any other information below:

_____

The purpose of the disclosure and/or exchange of information is to:

☐Yes or ☐No Report results of substance use/DUI assessment and recommendations
☐Yes or ☐No Facilitate the provision of services
☐Yes or ☐No Summarize course of services provided
☐Yes or ☐No Report on Progress/Compliance
☐Yes or ☐No Clearly specify any other purpose: _____

I understand that my alcohol and /or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent, *in writing*, 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 90 days following the date of termination of services with The Right Step, Inc.**

I understand that I could be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

_____ ____/____/____
(Client Signature) Date of Signature

_____ ____/____/____
(Signature of parent/guardian when required for minor under age of thirteen) Date of Signature

_____ ____/____/____
(Signature of agency representative) Date of Signature

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