New Beginnings Counseling and Support Services Consent to Release and Exchange Information

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Section A Client Information** | | | | | | | | | | | | | | | | | | | | |
| Client Name | |  | | | | | | | | | | | | | | | | | | |
| Address | |  | | | | | | | | | | | | | | | | | | |
| Date of Birth | |  | | | | | | Phone Number | | | | |  | | | | | | | |
| **Section B Other Medical Practitioner/Behavioral Health Agency/Government Agency/Parent/Other Person** | | | | | | | | | | | | | | | | | | | | |
| Name | | | |  | | | | | | | | | | | | | | | | |
| Agency, If Applicable | | | |  | | | | | | | | | | | | | | | | |
| Address | | | |  | | | | | | Fax | |  | | | | | | | Phone |  |
| **Section C Information Being Requested or Authorized to Send** | | | | | | | | | | | | | | | | | | | | |
| **New Beginnings is requesting the following information about the client in Section A** | | | | | | | | | | | | | | | | | | | | |
|  | GAIN Assessment/Drug & Alcohol Assessment | | | | | | | |  | | SUD Tx Plan | | | | | | | | | |
|  | Psychiatric Evaluation | | | | | | | |  | | Bio-Psycho-Social Eval/Med-Soc Hx | | | | | | | | | |
|  | Mental Health Comp | | | | | | | |  | | Mental Health Tx Plan | | | | | | | | | |
|  | Medical History/ Last Physical, Dental, or Eye Exam | | | | | | | |  | | Medication Records Past and Present/Rx’s and Reasons for Them, Dates Prescribed, Dosages, Refill Info | | | | | | | | | |
|  | Court Related Information | | | | | | | |  | | Probation/Parole Progress Reports | | | | | | | | | |
|  | Admission/Discharge Summary | | | | | | | |  | | Laboratory Results/Drug Testing | | | | | | | | | |
|  | Case Management Plans/Progress | | | | | | | |  | | School Records: | | | | | | | | | |
|  | Other: | | | | | | | |  | | Other: | | | | | | | | | |
|  | | | | | | | |  | | | | | | | | | |
| **Section D The Above Information is Being Requested or Authorized to Send for the Following Purposes** | | | | | | | | | | | | | | | | | | | | |
|  | SUD Services | | | | | | | |  | | Mental Health Services | | | | | | | | | |
|  | Case Management | | | | | | | |  | | HIV/AIDS Related Information | | | | | | | | | |
|  | RSS Services | | | | | | | |  | | Legal Services | | | | | | | | | |
|  | Visitation Services | | | | | | | |  | | DDA Services | | | | | | | | | |
|  | CBRS/HI/BI/HS Services | | | | | | | |  | | Coordination of Care for Client in Section A | | | | | | | | | |
|  | Other: | | | | | | | |  | | Other: | | | | | | | | | |
|  | | | | | | | |  | | | | | | | | | |
| **Section E Legal Disclosure of Participant Rights to Confidentiality** | | | | | | | | | | | | | | | | | | | | |
| \*I may refuse to sign this form if I chose, without fear of this agency conditioning treatment, payment, enrollment or eligibility for benefits, unless allowed by law. I may request a copy of this form at any time.  \*I understand that my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, as well as the Health Information Portability and Accountability Act (HIPPA) of 1996, 45 CFR Parts 160 and 164 Subparts A and E and cannot be disclosed without my written consent unless otherwise provided for in the regulations.  \*To the party receiving information from New Beginnings: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulation (42) CFR Part 2 prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of information is not sufficient for this purpose. | | | | | | | | | | | | | | | | | | | | |
| **Section F Consent of the Confidential Exchange of Information** | | | | | | | | | | | | | | | | | | | | |
| \*This consent is valid for One Year from the date signed but can be revoked at any time-either verbally or in writing, with the understanding that some information may have already been exchanged when and if a revocation is given.  I, the client specified in Section A, do hereby freely, voluntarily, and without coercion, authorize New Beginnings Counseling and Support Services and the agency or person in Section B, to release, exchange, and receive the information stipulated above in section C for the expressed purposes stipulated in Section D. | | | | | | | | | | | | | | | | | | | | |
| Client Signature | | |  | | | | | | | | | | | | | Date | |  | | |
| Guardian Signature | | |  | | | | | | | | | | | | | Date | |  | | |
| Signature of New Beginnings Representative | | | | | | |  | | | | | | | | | Date | |  | | |
| I Do *NOT* Want Information Shared With: | | | | | | | | | | | | | | | | | | | | |
| My PCP/Medical Practitioner | | | | |  | My other Behavioral Health Provider | | | | | | | |  | Other: | |  | | | |
|  | | | |