Authorization to Disclose Information
Twin County Recovery Services, Inc.

I, ____, hereby authorize Twin County Recovery Services, Inc. to share/exchange the following information and/or documentation regarding myself with:

____

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Diagnosis, Treatment Recommendations and Prognosis
- Attendance & Compliance with Treatment Program
- Treatment Goals & Objectives, Progress & Problem Areas
- Discharge Summary & Aftercare Recommendations
- Medical Records / Physical Information
- Psycho-social history and Information
- Urine drug screening results
- Other (please specify) ____

The purpose of this authorization is to:
- Monitor my participation/compliance with the requirements of Twin County Recovery Services, Inc.
- To enable judges, attorneys, case workers, case managers, therapists, physicians and all concerned others to support my treatment goals.
- To complete assessment / evaluation / provide collateral information
- Enhance Insurance benefits, including disability claims and eligibility
- Provide Dept. of Motor Vehicles and/or DDP information necessary to reapply for or regain my license.
- Other (please specify) ____

Duration:
This consent, unless otherwise specified, will remain in effect for the duration of treatment and for 90 days post-discharge. I do have the right to revoke this consent at any time either orally or in writing.

Duration (if different) ____

I understand that my chemical dependency treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I further understand that generally, Twin County Recovery Services, Inc. may not condition my treatment on whether or not I sign a consent form, but that in limited circumstances I may be denied treatment if I do not agree to sign a consent form, this disallowing them to collect needed collateral information regarding my substance use / medical history.

____________________________	______________________________________
Date	**Client Signature**
____________________________	______________________________________
Date	**Parent/Guardian Signature (in case of minor)**
____________________________	______________________________________
Date	**Signature of Witness**