CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION
Interior AIDS Association's Interior Medication Assisted Treatment

I, _____ authorize the **IAA's Interior Medication Assisted Treatment** to exchange with
(patient's name)

_____the following information: (please initial that you understand the following info could be communicated):

_____My name and other personal identifying information
_____My status as a patient in alcohol and/or drug treatment
_____Attendance and compliance with treatments
_____Recommendations for further treatment services
_____Discharge plan/summaries to include discharge dates and status
_____Name of agency where I received treatment
_____Assessment/evaluation results
_____Other, must be specific_____

The purpose of this exchange, authorized by this consent, is to provide information to facilitate continuing substance abuse education/treatment OR _____. **THIS RELEASE EXPIRES ON** _____
Date (no longer than 90 days from signature)

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 C.F.R. Pts 160 &164 and **cannot be disclosed without my written consent unless otherwise provided for in the regulations**. I understand that ***I may revoke*** this consent 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 in 90 days. I understand that if I choose to revoke this consent the revocation must be in writing.

I understand that generally the IMAT may not condition my treatment on whether I sign this consent form, but in certain limited circumstances I may be denied treatment and/or services if I do not sign the consent form.

Information will be shared by: _____phone _____fax _____US Mail _____email
(Consumer must initial)

_____ _____
Consumer signature Date

_____ _____
Parent, guardian, or WITNESS signature Date

REVOKE CONSENT

_____ _____
Consumer signature Date