GatewayRehab
Addiction Recovery & Self Renewal

Release of Information

Patient Name_____________________ DOB_______________ Client ID__________________________

Authorized Individual/Organization (Name & Title:____

Address________________________________City______________________State_________Zip Code____________

Phone Number___________________________Facsimile Number_______________________________

Purpose of Disclosure: ☐Health Insurance Billing/Authorization ☐Continuity of Care ☐Collateral Contact Information

☐ Treatment Planning/Case Management ☐Continued Employment/Fitness for Duty ☐FMLA ☐Short Term Disability

☐ Other (Specify):______________________________

Disclosure of information pertains to dates of treatment ranging from:

(date) ______________ - (date/"discharge") ______________________

PA Code 255.5 limits the information that may be disclosed to Insurance Companies/Funding Source, Criminal Justice Systems/Government Agencies.

Is this Release of Information to an Insurance Company, School or Government Agency? ☐Yes ☐No

Mandated Treatment: I understand that this consent will remain in effect and cannot be revoked verbally or in writing until there has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceedings under which I may be court ordered or otherwise mandated into treatment.

If Yes, the Release of Information is limited to the following:

- *Whether the client is or is not in treatment*
- *The Prognosis of the patient*
- *The nature of the project*
- *A brief description of the progress of the patient*
- *A short statement as to whether the patient has relapsed into drug or alcohol abuse and the frequency of such relapse.*

Is the Release of Information to an Employer? ☐Yes ☐No

If Yes, the Release of information is limited to the following:

- *Whether the client has or is receiving treatment*

Is the Release of Information to an Employee Assistance Program? ☐Yes ☐No

If Yes, the Release of Information is limited to the following:

- *Evaluation Date and Recommendations*
- *Progress Letter*
- *Treatment Dates*
- *Monthly reports indicating compliance with recommendation(s)*
- *Discharge Status*

Other Release Type? ▢**Yes** ▢**No**

Specify the type of information to be disclosed (check all that applies):

▢*To explain and/or answer questions pertaining to the Intake Process and/or Gateway Rehab services.*
▢*To gather information to assist in my evaluation or social/psychological status including chemical use.*
▢*Invite family members or concerned persons to participate in the Family Wellness Group,*
▢*Notify family members or concerned persons listed of my progress during treatment and of my discharge.*
▢*Progress Notes*
▢*Diagnostic Assessment Information*
▢*Lab Results*
▢*Urine Testing*
▢*HIV/AIDS Testing or Status Pregnancy Testing*
▢*Prenatal Care*
▢*Diagnoses*
▢*Discharge Summary/Planning*
▢*Information on Mental Illness and and/or Treatment*
▢*Medication*
▢*Insurance Cards*
▢*Immunization Records*
▢*Academic/School Records*
▢*Demographics*
▢*Other (Specify)*____

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I also understand that I may revoke this consent verbally or in writing at any time except to the extent that information has been released prior to the date of revocation by contacting Medical Records. In any event, this consent shall expire one year from the date of signature.

Unless I have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information permitted by this authorization in any manner that we deem to be appropriate and permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C. F. R. Part 2.

____ _____________
Patient Signature Date

____ _____________
Parent/Responsible Party Signature (If required) Date

____ _____________
Witness Signature Date

▢Copy Accepted ▢Copy Refused