Sequoia Springs
Trauma Healing Center, Inc.
2055 N. Kolb Road, Suite 121
Tucson, AZ 85715
(520) 838-0918

CONSENT FOR THE RELEASE OF CONFIDENTIAL MENTAL HEALTH, ALCOHOL OR DRUG TREATMENT INFORMATION

Patient Name _____ Date of Birth_____
This authorization must be written, dated and signed by the client or by a person authorized by law to give authorization.

Sequoia Springs Trauma Healing Center, Inc. (please initial applicable):

_____ **OBTAIN** my healthcare information from:
_____ **PROVIDE** my healthcare information to:

Name/Organization: _____

Address:_____City:_____State:_____Zip: _____

Phone:_____Fax: _____

Sequoia Springs Trauma Healing Center, Inc. may obtain and/or provide the following health care information (**initial all that apply**). By initialing the spaces below, I specifically authorize the release of the following information:

_____ Diagnostic Assessments
_____ Number/Dates of Sessions
_____ Discharge Summary
_____ Treatment Summary/Impressions
_____ Medical History
_____ Drug and Alcohol Treatment Information
_____ All Health Care Information
_____ Billing
_____ In Case of Emergency
_____ Other (please specify):
_____
_____

This information may be communicated:

_____Verbally Only ____Written Only ____ Both Verbally and in Writing

The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.

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 CFR, Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CRF, Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in 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 as follows: _____ (e.g. 6 months, 1-year, specific date or event)

_____ _____
Client/Legally Authorized Representative Signature Date

_____ _____
Witness Signature Date

Federal rules prohibit making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.