

For Substance Abuse Clients: I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that, except for action already taken, I may revoke this consent at any time.

For Mental Health Clients: I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information. I also understand that, except for action already taken, I may revoke this consent at any time.

Protected Health Information:

I understand that my health information is protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160& 164, but once this information is disclosed pursuant to this form, it may no longer be protected by HIPAA and further redisclosure may occur. 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 the consent.

I understand that generally _____
(Name of treatment program)

may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

If I do not revoke this consent, it expires automatically as follows:

1. Upon closure of my Child Protective Services/In-Home Services/Out of Home Services case; or
2. One year from the date this consent is signed; whichever occurs first.

Date signed

Client's signature

Date signed

X _____
Legally Responsible Person

_____ Client has received a copy of this consent form for his/her records.