RECOVERY TECHNOLOGY L.L.C.

Mutual Consent for Release of Confidential Information

Client Name_____ Case #_____Date_____

DOB: _____ I do authorize and request:

Recovery Technology LLC
1200 N West Avenue, Suite 400
Jackson, MI 49202
Phone 517-780-3336 Fax 517-796-4561

To verbally and or in writing communicate with:

Name: _____ Phone: _____
Address: _____ Fax: _____
City, State, Zip: _____ Relationship: _____

To disclose the following information:

- ☐ Diagnosis
- ☐ Psychological Testing
- ☐ Treatment History
- ☐ Vocational Assessment
- ☐ Current/Past Medications
- ☐ Lab Results/Drug Screens
- ☐ Hospitalization Information
- ☐ Psychiatric Evaluation
- ☐ Psychosocial History
- ☐ History/Status Legal Issues
- ☐ Employment Information
- ☐ History/Physical Exam
- ☐ Medical Information
- ☐ Discharge Summary
- ☐ School/Records/Behaviors
- ☐ Insurance Information
- ☐ Treatment Progress Notes
- ☐ OT/PT/Speech Information
- ☐ Eligibility Determination
- ☐ Return to Work/School
- ☐ Substance Abuse History
- ☐ Other: _____

To determine:

☐ Need and type of treatment ☐ Coordination of Services ☐ Other: _____

I understand that my alcohol and/or drug treatment records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42, CFR Part 2: the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 25 CFR Parts 160 & 164; and the Mental Health Code, Section 330.1748 of the Public Act, and cannot be re-disclosed without my written consent unless otherwise provided for in the regulations.

I understand that information contained in the medical record may include mental health treatment, alcohol or drug abuse treatment, Human Immunodeficiency Virus or AIDS, or a serious communicable or sexually transmitted disease.

I hereby authorize the release of my substance abuse records. Client Initial: _____

I understand that I may revoke this consent, verbally or in writing at any time except to the extent that action has been taken, its reliance on it, and that in any event this consent shall expire one year from the date of the signature or sixty days after the date of my discharge from Recovery Technology LLC services unless specified below.

I understand that revoking this authorization prior to completion of court ordered treatment might affect my association with the court.

Verbal Revocation Client Initial: _____ Date: _____
Written Revocation Client Initial: _____ Date: _____
Event/Condition presented to revoke consent: _____

I understand that authorizing the disclosure of health information is voluntary and that I may refuse to sign his authorization; however, my request to release information will not be fulfilled. I understand I may inspect or copy the information to be used or disclosed. I understand that the covered entity seeking this authorization is not conditioning treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

Client Signature: _____ Date: _____
Guardian Signature: _____ Date: _____
Witness Signature: _____ Date: _____