PORT GARDNER BAY RECOVERY, INC.

Client Demographic

Name:			Date:
Address:		Email:	
City	State:	Zip:	Phone:
Date of Birth:	Current Age:	Last 4 of SS#:	DL #:
Emergency Contact:		Phone:	
Referred By:		Military Service:	

What was the reason you scheduled this appointment? ☐ Family pressure ☐ Employer intervention
☐ Physician intervention ☐ Legal pressure ☐ Child custody ☐ Reinstate driving privileges
☐ DUI? If so, date and BAC/BAL _____ Driving Abstract available for review ☐ No ☐ Yes
☐Self-motivated, reason(s): _____ ☐ Other reason(s): _____
Have your parental rights been terminated? □ No □ Yes, if yes, when? _____ By whom: _____
Please explain: _____
Have you ever had a no contact order against you? □ No □ Yes
If yes, by whom and when? _____

FAMILY HISTORY

Where were you born? _____ Where were you raised? _____
How many siblings do you have? _____ What is Your Birth Order? _____
How would you describe your childhood?
□ Supportive □ Unsupportive □ Passive □ Troubled

ENVIRONMENTAL

Current Marital Status: ☐ - Single ☐ - Married ☐ - Separated ☐ - Divorced ☐ - Widowed ☐ - In Partnership
Number of times married/divorced? _____ Number of children _____ Do you live with your spouse/partner? ____
How many people do you live with and what is your relationship? _____
Have you ever been a victim of domestic violence or other type of assault? ☐ No ☐ Yes, if yes please explain:

_____

_____

If yes, were alcohol and/or other drugs a factor? ☐ No ☐ Yes, if yes please explain:

_____

_____

EDUCATION HISTORY

Years of Education Completed: _____ Type of Degree: _____
College or Trade School: _____ Focus: _____
How would you rate your English reading and writing skills? _____
Is English your primary language? ☐ Yes ☐ No, primary language: _____
If no, will you require interpreter services for any education or treatment program? ☐ Yes ☐ No

EMPLOYMENT HISTORY

Current Employment Status: _____ Length of Employment: _____
Name of Employer: _____ Job Title/Field of Employment: _____

MEDICAL HISTORY

Which of the following medical conditions do you currently have, or have had in the past?

Being treated?	Y	N
□ Anemia or blood disorder	□	□
□ Rheumatic or scarlet fever	□	□
□ Chest pains	□	□
□ Fainting Spells	□	□
□ Kidney Disease or Bladder Infection	□	□
□ Liver Disease-Hepatitis or Jaundice	□	□
□ Cancer – Type: _____	□	□
□ Diabetes	□	□
□ High or Low Blood Sugar: _____	□	□
□ Tuberculosis	□	□
Last test date: _____ Test Results: _____		
□ Ulcers or Pain in the Stomach	□	□
□ Epilepsy	□	□
□ Heart Trouble	□	□
□ Shortness of Breath	□	□

Being treated?	Y	N
□ High or low blood pressure	□	□
□ Chronic Pain	□	□
□ Glaucoma	□	□
□ Allergies (food or drug)	□	□
If yes, to what? _____	□	□
□ Physical Injury	□	□
If yes, what type? _____		
□ Communicable Disease: _____	□	□
□ Other: _____	□	□
FOR FEMALES:		
□ Menopause or Premenopausal	□	□
□ Premenstrual Syndrome	□	□
□ Pregnancy □ Suspected □ Confirmed		
Number of Months: _____ Number of Children: _____		
Referred to First Steps? □ Yes □ No		

Have these, or any other medical conditions been impacted by your use of alcohol or other drugs?
□ No □ Yes – If Yes, in what manner? _____

How would you describe your physical health? ☐ Poor ☐ Average ☐ Good ☐ Excellent

Current physical illnesses, other than withdrawal, that need to be addressed or which may complicate treatment (from checklist): _____

Date of last physical exam: _____ Physician name: _____

Current health issues being treated: _____

Are you taking any medications?

Name of Medication	Dosage/frequency	Reason

Do you currently use nicotine? □ No □ Yes, if yes, at what age did you start? _____

If yes: □ Smoke □ Chew □ Vape □ Patches/Gum □ Other

How much do you use per day? _____

BEHAVIORAL HEALTH

Do you participate in gambling activities? □ No □ Yes, if yes:

Which activities have you engaged in: □ Casino Gambling □ Online gambling/gaming for money

□ Played cards (for money) □ Betting on sports, racing, etc. □ Lottery □ Other: _____

During the past 12 months did you have such financial trouble as a result of your gambling that you had to get help with living expenses from family, friends or welfare? □ No □ Yes

Have you had a significant period (that was not a direct result of drug/alcohol use) in which you experienced any of the following?

☐ Anxiety/nervousness ☐ Grief/loss issues ☐ Sleep disturbances ☐ Hostility/violence
☐ Inability to comprehend ☐ Depression ☐ Phobias/paranoia/delusions ☐ Loss of appetite
☐ Eating disorders, if checked: ☐ Anorexia ☐ Bulimia ☐ Binge Eating Disorder ☐ Other: _____
☐ Hallucinations; if checked: ☐ Auditory ☐ Visual ☐ Other sensory (Type: _____)

When did you experience them and what did you do about it? _____

Is there a history of mental illness in your family? ☐ No ☐ Yes, If yes, who and what is the illness?

RELATIVE	ILLNESS	STATUS

Have you ever been diagnosed with a mental health condition? ☐ No ☐ Yes, if yes what was the diagnosis?

DIAGNOSIS	WHO DIAGNOSED IT?	WHERE?	WHEN?

Are you currently being treated for the diagnosed mental health condition? ☐ No ☐ Yes
Who is treating you? _____ How often do you see your provider? _____
Have you continued to use alcohol or other drugs despite having identified problems that were caused or made worse because of that use? ☐No ☐ Yes If yes, describe: _____

Have you ever been diagnosed with a learning disorder or any other cognitive disorder? ☐ No ☐ Yes, if yes,
What is the learning disability or cognitive disorder? _____
When were you diagnosed? _____ Who diagnosed it? _____
What strategy was developed to adjust and manage it? _____

Do you have any problems with understanding written materials? ☐ No ☐ Yes
If yes, what is the problem? _____

Have you ever received any help with this problem? ☐ No ☐ Yes, if yes, what kind of help? _____

Do you need any help to understand written or verbal information? ☐ No ☐ Yes, if yes, what kind of help do you need? _____

ALCOHOL USE HISTORY

How old were you when you first tried alcohol? _____What did you experience? _____
How old were you when you began to use alcohol on a regular basis? _____
In the past 12 months, what types of alcohol beverages did you drink? _____
How often do you drink? _____ How much during each drinking episode? _____
What is the minimum to maximum number of drinks you might consume in any one drinking episode? _____
How many drinks does it take to make you feel the effect? _____
How many times in the past year have you become intoxicated? _____
Date of last alcohol consumption? _____
What is your opinion of your alcohol use? _____
Is there any history of problematic alcohol or drug use in your family? □ No □ Yes
If yes, who had the problem? _____

OTHER DRUG USE HISTORY

Type of Drug	Used?	Date of First Use	Date of Last Use	Used How
Amphetamine				
Marijuana				
Cocaine				
Opiate				
Sedative/Tranquilizer				
Hallucinogen				
Phencyclidine				
Inhalant				
Other(s)				

What is your primary drug of choice and why? _____

What is your secondary drug of choice and why? _____

What was the longest period of time you have ever gone without using your drug of choice and why?

_____

_____

What is your opinion of your drug use? _____

TREATMENT HISTORY

Have you ever had any education, counseling, or treatment for alcohol and/or other drugs? ☐ No ☐ Yes *(including prescription medications)*

If yes, what type of treatment or education were you involved in, and for what reason?

_____

_____

_____

How effective was this program to you? _____

Did you remain abstinent from alcohol and/or other drugs while you were involved in the program? ☐ No ☐ Yes

How long did you remain abstinent from alcohol and/or other drugs after completing the program? _____

Have you ever felt the need to stop using alcohol and/or other drugs? ☐ No ☐ Yes, if yes please explain:

_____

_____

How many serious attempts have you made? _____ What was the longest period you were able to achieve? _____

What were the outcomes of any failed attempts?

_____

_____

Do you utilize any support groups as a means of helping you to not use alcohol/other drugs? ☐ No ☐ Yes

If yes, what type of support group? _____

How often do you attend these support groups? _____ How effective are they in helping you? _____

How many of your closest friends consume alcohol or use other drugs? _____

How many of your closest family members consume alcohol or use other drugs? _____

Does your spouse/partner/roommate consume alcohol or use other drugs? _____

Are alcohol and/or other drugs available in your home or work environment? ☐ No ☐ Yes

LEGAL HISTORY

Have you ever been charged with:

☐ DUI
☐ MIP Negligent Driving 1st degree
☐ Reckless driving
☐ VUCSA charge
☐ Open container
☐ Assault/Domestic Violence
☐ Other alcohol and/or drug-related charges: _____

Date	Type of Charge	Disposition	Court	BAC

CURRENT CHARGE

Attorney Name: _____ Phone: _____ Fax: _____
Address: _____
Date of Charge: _____ Date of next Hearing: _____ Case #: _____
Court: _____ BAC Reading(s): _____
If the BAC test was refused, please explain why?

_____

_____

Please describe the events leading up to your arrest:

_____

_____

_____

_____

Did you provide us with a copy of your complete driving record? ☐ No ☐ Yes
Did you provide us with a copy of your legal history? ☐ No ☐ Yes
Did you provide us with a copy of the police report? ☐ No ☐ Yes
Your driving record, legal history, and police report must be provided for all evaluations related to legal charges.

_____ _____
Client Signature Date

_____ _____
Witness Signature Date

PORT GARDNER BAY RECOVERY, INC.

MAST: Michigan Alcoholism Screening Test

Yes	No		
☐	☐	1.	Do you feel that you are a normal drinker (by "normal" we mean do you drink less than, or as much as, other people)?
☐	☐	2.	Have you ever awakened the morning after some drinking or drugging the night before, and found that you do not remember a part of the evening?
☐	☐	3.	Does your spouse, parent or significant other ever worry or complain about your drinking?
☐	☐	4.	Can you stop drinking without a struggle after one or two drinks?
☐	☐	5.	Do you ever feel guilty about your drinking?
☐	☐	6.	Do friends or relatives think you are a normal drinker?
☐	☐	7.	Do you ever try to limit your drinking to certain times of the day or certain places?
☐	☐	8.	Are you able to stop drinking when you want to?
☐	☐	9.	Have you ever attended a meeting of Alcohol Anonymous?
☐	☐	10.	Have you ever gotten into fights when drinking?
☐	☐	11.	Has drinking ever created problems between you and your spouse, a parent or significant other?
☐	☐	12.	Has your spouse, parent, or significant other ever gone to anyone for help about your drinking?
☐	☐	13.	Have you ever lost friends or significant other because of your drinking?
☐	☐	14.	Have you ever gotten into trouble at work because of your drinking?
☐	☐	15.	Have you ever lost a job because of your drinking?
☐	☐	16.	Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?
☐	☐	17.	Do you drink before noon fairly often?
☐	☐	18.	Have you ever been told that you have liver trouble or cirrhosis?
☐	☐	19.	After heavy drinking, have you ever had delirium tremens (DTs), severe shaking, heard voices, or saw things that really are not there?
☐	☐	20.	Have you ever gone to anyone for help for your drinking?
☐	☐	21.	Have you ever been in the hospital because of your drinking?
☐	☐	22.	Have you ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital where drinking was a part of the problem that resulted in your hospitalization?
☐	☐	23.	Have you ever been seen at a mental health clinic or gone to a physician, social worker, or clergy for help with any emotional problem in which drinking was a part of the problem?
☐	☐	24.	Have you ever been arrested for driving under the influence of alcoholic beverages or non-prescription drugs?
☐	☐	25.	Have you ever been arrested, even for a few hours, because of other behavior when drinking?

Score: _____

_____ _____

Client Signature Date

_____ _____

Witness Signature Date

PORT GARDNER BAY RECOVERY, INC.

DAST: Drug Abuse Screening Test

Yes	No	
☐	☐	1. Have you used drugs other than those prescribed for medical purposes?
☐	☐	2. Have you abused prescription drugs?
☐	☐	3. Do you abuse more than one drug at a time?
☐	☐	4. Can you get through the week without drugs? (other than for medical purposes)
☐	☐	5. Are you always able to stop using drugs when you want to?
☐	☐	6. Do you abuse drugs on a continuous basis?
☐	☐	7. Do you try to limit your drug use to certain situations?
☐	☐	8. Have you had "blackouts" or "flashbacks" as a result of your drug use?
☐	☐	9. Do you ever feel bad about your drug use?
☐	☐	10. Does your spouse (parent, significant other) ever express concern about your consumption of drugs?
☐	☐	11. Do your friends or relatives know or suspect you use or abuse drugs?
☐	☐	12. Has drug use ever created problems between you and your spouse or significant other?
☐	☐	13. Has any family member ever sought help for problems related to your drug use?
☐	☐	14. Have you ever lost friends because of your use of drugs?
☐	☐	15. Have you ever neglected your family or missed work because of your use of drugs?
☐	☐	16. Have you ever been in trouble at work because of drugs?
☐	☐	17. Have you ever lost a job because of drug use?
☐	☐	18. Have you ever gotten into fights when under the influence of drugs?
☐	☐	19. Have you ever been arrested because of unusual behavior while under the influence of drugs?
☐	☐	20. Have you ever been arrested for driving under the influence of drugs?
☐	☐	21. Have you ever engaged in illegal activities in order to obtain drugs?
☐	☐	22. Have you ever been arrested for possession of illegal drugs?
☐	☐	23. Have you ever experienced withdrawal symptoms as a result of heavy drug intake?
☐	☐	24. Have you ever had medical problems as a result of your drug use (Memory loss, hepatitis, convulsions, bleeding)?
☐	☐	25. Have you ever gone to anyone for help with a drug problem?
☐	☐	26. Have you ever been in the hospital for medical problems related to your drug use?
☐	☐	27. Have you ever been in a treatment program specifically related to drug use?
☐	☐	28. Have you been in treatment as an outpatient for problems related to drug use?

Score: _____

_____ _____

Client Signature Date

_____ _____

Witness Signature Date

PORT GARDNER BAY RECOVERY, INC.

COUNSELOR DISCLOSURE INFORMATION

DESCRIPTION OF METHODS AND TECHNIQUES USED IN THE PROGRAM

Use of standard teaching, treatment and counseling techniques to assist the patient in becoming aware of the problems associated with the addictive use of alcohol and/or other drugs and methods of attaining and maintaining an abstinent lifestyle. Standard insight, supportive, motivational enhancement, group and individual counseling will be used to assist in the integration of the teaching materials into the patient's lifestyle.

TREATMENT PHILOSOPHY

These programs provide patients with treatment for Alcohol and other Drug addiction and abuse. Concerns for the psychological, physiological, nutritional and spiritual aspects of these problems will be identified and reviewed. The programs require abstinence from the use of non-prescription drugs and alcohol. The program will include one or more of the following: teaching, individual and group counseling, trigger identification, relapse prevention, anger and stress management, parenting, conflict resolution and discharge planning. Alcohol and drug dependence are progressive, incurable diseases affecting the physical, emotional/psychological, and spiritual functioning of an individual. The progression of the disease can be arrested by abstinence and a recovery lifestyle.

State law requires patients to be given the following information:

> "Counselors practicing counseling for a fee must be registered or certified with the Dept. of Licensing for the protection of the public health and safety. A registration of an individual with the department does not include recognition of any practice nor necessarily implies the effectiveness of any treatment."

The Washington State Counselor Credentialing Act was enacted to:

- Provide protection for public health and safety; and to
- Empower the citizens of the state of Washington by providing a complaint process against those counselors who would commit acts of unprofessional conduct.

Counselors must meet standards of professional conduct. The following is a list of unprofessional conduct listed in the Revised Code of Washington (RCW 18.130.180):

- Fraud, fraudulent or misleading advertising.
- The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of counseling.
- Incompetence, negligence, or malpractice resulting in injury or unreasonable risk to the client.
- Misrepresentation or concealment of a material fact in obtaining a license or in reinstatement thereof;
- Continuing to practice despite suspension, revocation, or restriction of the individual's license to practice any health care profession by competent authority in any state federal or federal jurisdiction.
- The possession, use, prescription for use, or distribution of controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes.
- Violation of any state of federal law or rules, or rules of any health agency.
- Failure to comply with an order issued by the disciplining authority or a stipulation for informal disposition entered into with the disciplining authority
- Aiding or abetting an unlicensed person to practice when a license is required unless exempt by law.
- Practice beyond the scope of practice as defined by law or rule;
- Misrepresentation or fraud in any aspect of the conduct of the business or profession;
- Failure to adequately supervise auxiliary staff to the extent that the consumer's health or safety is at risk.

- Engaging in a profession involving contact with the public while suffering from a contagious or infectious disease involving serious risk to public health.
- Promotion for personal gain of any unnecessary or inefficacious drug, device, treatment, procedure, or service.
- Conviction of any gross misdemeanor or felony relating to the practice of the person's profession.
- The procuring, or aiding or abetting in procuring a criminal abortion;
- The offering undertaking or agreeing to cure by a secret method, procedure, treatment.
- The willful betrayal of a practitioner-patient privilege as recognized by law;
- Violation of the rebating laws which includes payment for referral of clients.
- The use of threats or harassment against any patient or witness to prevent them from providing evidence in a disciplinary proceeding or other legal action.
- Drunkenness or habitual intemperance in the use of alcohol or addiction to alcohol.
- Abuse of a client or patient or sexual contact with a client or patient;

Anyone having any questions or wishing to file a complaint should write or call:

Department of Health (360) 753-1761
Professional Licensing Services Division
Counselor Section
Post Office Box 47869
Olympia, WA 98504-7869

COUNSELOR INFORMATION
Kimberli McCabe, CDP
Administrator
CDP# CP00002660

My signature below indicates that I have read and understand the above information. I have had the opportunity to have any questions answered. I understand I can receive a copy of the above information upon request.

_____ _____
Client Signature Date

_____ _____
Witness Signature Date

PORT GARDNER BAY RECOVERY, INC.

CLIENT RIGHTS

Your rights as a client are mandated by Washington State Law and protected by PORT GARDNER BAY RECOVERY, INC. You have the right to:

- Receive services without regard to race, creed, national origin, religion, gender, sexual orientation, age or disability;
- Practice the religion of choice as long as the practice does not infringe on the rights and treatment of others or the treatment service. Individual participants have the right to refuse participation in any religious practice;
- Be reasonably accommodated in case of sensory or physical disability, limited ability to communicate, limited English proficiency, and cultural differences;
- Be treated with respect, dignity and privacy, except that staff may conduct reasonable searches to detect and prevent possession or use of contraband on the premises;
- Be free of any sexual harassment;
- Be free of exploitation, including physical and financial exploitation;
- Have all clinical and personal information treated in accord with state and federal confidentiality regulations;
- Review your clinical record in the presence of the administrator or designee and be given an opportunity to request amendments or corrections;
- Receive a copy of agency complaint and grievance procedures upon request and to lodge a complaint or grievance with the agency, or behavioral health organization (BHO), if applicable, if you believe your rights have been violated; and
- File a complaint with the department when you feel the agency has violated a WAC requirement regulating behavior health agencies.
- Be fully informed and receive a copy of the Client Grievance Procedure upon request.

Client Signature	Date
Witness Signature	Date

PORT GARDNER BAY RECOVERY, INC.

CONFIDENTIALITY OF CLIENT RECORDS

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by Federal Law and Regulations. The program may disclose to someone outside the program that an individual is attending the treatment program. Agency Staff may not release information about, or identifying a person as an alcohol or drug abuser, unless:

1. The patient consents in writing on the appropriate form.
2. The disclosure is authorized by court order,
3. The disclosure is made to medical personnel in a medical emergency or to a qualified personnel for research, audit or program evaluation, in accordance with the applicable law.
4. The disclosure is required by reportable instances of child/elder abuse.
5. The disclosure is required by the counselor making "duty to warn" statements as required by law.

Violations of the Federal law and regulations by a staff member is a crime. Suspected violations may be reported to the appropriate authorities in accordance with Federal regulations.

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 the Health Insurance Portability and Accountability Act, (HIPPA), 45 CFR Parts 160 & 164 and cannot be disclosed without my written consent, unless otherwise provided for in the regulations.

Client Signature	Date
Witness Signature	Date

PORT GARDNER BAY RECOVERY, INC.

HIV/AIDS BRIEF RISK INTERVENTION

It is a Washington State Law that all people entering a substance use education or chemical dependency treatment program receive information about HIV/AIDS. In addition to the information in this section, you will also receive more detailed and comprehensive information while you are involved in your program at PORT GARDNER BAY RECOVERY, INC.

Facts about the transmission of HIV: The **H**uman **I**mmunodeficiency **V**irus (HIV) is transmitted from person to person most commonly through sexual contact that involves the exchange of bodily fluids (i.e. semen, vaginal secretions, and blood) as well as by direct blood-to-blood contact as can occur with shared needles and syringes. **HIV is not transmitted through casual contact such as close proximity, sneezing, and touching.** The virus must get **into** the blood system to infect a host. HIV is not known to be an airborne disease.

Preventing exposure to HIV: You can avoid exposure and decrease your risk of HIV infection by:

- Not engaging in unprotected sexual contact.
- Having a monogamous sexual relationship and neither you nor your partner been infected with HIV
- Being aware of your partner's sexual history
- Not using injectable drugs (or if you do use injectable drugs, using only new sterilized needles – not shared)
- Not engaging in sexual contact with people who engage in high-risk behaviors that may expose them to HIV infection (using injectable drugs, being sexually promiscuous)
- Using latex condoms (**note:** condoms do not guarantee safety but, if used correctly, can substantially reduce the risk of HIV and other sexually transmitted diseases).

Resources for Information and Counseling:

- AIDS Hotline: National –800-342-AIDS (2437) or State –800-272-AIDS (2437)
- Snohomish Health District: 425-339-5251
- American Red Cross: Local –425-252-4105 or National –877-272-7337

_____ _____

Client Signature Date

_____ _____

Witness Signature Date

PORT GARDNER BAY RECOVERY, INC.

TUBERCULOSIS (TB) SCREENING

Washington State Law requires that Alcohol/Drug Patients be screened for Tuberculosis (TB). While some of these questions may be very personal, or such that you may find offensive, please remember that this is for your protection. Tuberculosis is on the increase in our society, including among alcohol and/or drug addicted people. As a result, all Chemical Dependency Providers in the State of Washington are required to document TB screening in each patient file.

Please answer the following questions concerning possible exposure to, or infection of, Tuberculosis honestly. If you have any questions, please ask them during your time with the counselor.

1. Have you ever tested positive for TB infection?	☐ Yes	☐ No

If you answered YES to the Question 1, please answer the following, if you answered "NO" please skip to Question 2

Have you ever been treated for Latent TB Infection (LTBI)?	☐ Yes	☐ No
Did you complete treatment for LTBI?	☐ Yes	☐ No
Have you ever been diagnosed with TB?	☐ Yes	☐ No
Have you ever been treated for TB?	☐ Yes	☐ No
If Yes, did you complete treatment for TB?	☐ Yes	☐ No
2. Have you worked, lived, spent time with or been exposed to anyone who has been sick with TB in the last two years?	☐ Yes	☐ No
3. Have you lived or traveled in Africa, Western Europe, Russia, Mexico, Central or South America, Asia, India, or The Philippines?	☐ Yes	☐ No
4. Have you lived in or worked at a correctional facility, long-term care facility, or homeless shelter?	☐ Yes	☐ No
5. Are you infected with HIV?	☐ Yes	☐ No
6. Have you ever injected illegal drugs?	☐ Yes	☐ No
7. Do you smoke?	☐ Yes	☐ No

Client Signature _____ Date _____

Witness Signature _____ Date _____

LIST OF SNOHOMISH COUNTY AGENCIES

Name	Address	Phone	Fax
A New Spirit Recovery Program	22617 76th Ave. W, Ste. 101, Edmonds 98026	425-771-1194	425-771-4544
Alderwood Recovery	5108 196th St. SW, Ste. 208, Lynnwood 98036	206-719-5759	425-670-6578
Alpine Recovery Services – Lynnwood	4202 198th St. SW, Ste. 2, Lynnwood 98036	425-778-1136	425-778-1118
Alpine Recovery Services – Arlington	16404 Smokey Point Blvd., Ste. 109, Arlington 98223	360-658-1388	360-658-9842
Alternative Counseling	22727 Highway 99, Ste. 212, Edmonds 98026	425-776-6414	425-776-6420
Asian-American Chemical Dependency Treatment	5116 196th St. SW, Ste. 101, Lynnwood 98036	425-776-1290	425-776-1298
Assessment & Treatment Associates	13353 Bel-Red Rd., Ste. 101, Bellevue 98005	425-289-1600	425-289-1602
Behavioral Health Service – Stillaguamish	17014 59th Ave. NE, Arlington 98223	360-435-3985	360-659-3113
Bowen Recovery Center	1120 164th St. SW, Ste. I, Lynnwood 98087	425-787-5833	425-787-5899
Catholic Community Services – Everett	2610 Wetmore Ave., Everett 98201	425-258-5270	425-258-5275
Catholic Community Services – Marysville	1227 2nd St., Marysville 98270	360-651-2366	360-653-3119
Center for Counseling & Health Resources	547 Dayton St., Edmonds 98020	425-771-5166	425-670-2807
Center for Human Services	21907 64th Ave. W, Ste. 270, Mountlake Terrace 98043	206-362-7282	206-362-7152
Clearview Counseling	1106 Columbia Ave., Marysville 98270	360-653-0374	360-658-2019
Everett Treatment Services	7207 Evergreen Way, Ste. M, Everett 98203	425-347-9070	425-348-3676
Evergreen Manor	2601 Summit Ave., Bldg. C, Everett 98201	425-258-2407	425-339-2601
La Esperanza	20815 67th Ave. W, Ste. 201, Lynnwood 98036	425-248-4534	425-248-4536
Lakeside-Milam Recovery	11 SE Everett Mall Way, Bldg. F, Everett 98208	425-267-9573	425-823-3132
Options	11627 Airport Road, Suite A, Everett, WA 98204	425-742-6410	425-742-9350
Port Gardner Bay Recovery, Inc.	2722 Colby Ave., Ste. 515, Everett 98087	425-252-4656	425-252-4308
Providence Recovery Program	916 Pacific Ave., Everett 98206	425-258-7798	425-258-7379
Recovery Center at Valley General	17880 147th St. SE, Monroe 98272	360-794-1405	360-794-1493
Sea Mar Behavioral Health – Everett	5007 Claremont Way, Everett 98203	425-609-5505	425-609-5506
Sea Mar Behavioral Health – Lynnwood	19707 44th Ave. W, Ste. 101, Lynnwood 98036	425-977-2560	425-250-3015

PORT GARDNER BAY RECOVERY, INC.

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____ authorize **PORT GARDNER BAY RECOVERY, INC.**
(Please print full legal name of patient)

To/from: _____ , the following information:
(Name of person/Organization to which disclosure is to be made)

RESULTS OF EVALUATION
(Nature of the information, as limited as possible)

For the purpose of: **CASE REPORTING**
(Purpose of Disclosure, as specific as possible)

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 the Health Insurance Portability and Accountability Act, (HIPPA), 45 CFR Parts 160 & 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 at any time, except to the extent that action has been taken in reliance on it (e.g., probation, parole, etc.), and that in any event this consent expires automatically expire on:

Ninety (90) days from discharge date
(Date or condition of expiration)

FEDERAL LAW AND REGULATIONS DO NOT PROTECT ANY INFORMATION ABOUT SUSPECTED CHILD ABUSE OR NEGLECT FROM BEING REPORTED UNDER STATE LAW TO APPROPRIATE STATE OR LOCAL AUTHORITIES. (*See 42 U.S.C., 290ee for Federal laws and 42 CFR, Part 2 for Federal Regulations*)

_____ I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will.

_____ _____
Client Signature Date

_____ _____
Witness Signature Date

PORT GARDNER BAY RECOVERY, INC.

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____ authorize **PORT GARDNER BAY RECOVERY, INC.**
(Please print full legal name of patient)

To/from: _____ , the following information:
(Name of person/Organization to which disclosure is to be made)

LEGAL HISTORY, COMPLETE DRIVING RECORD, POLICE REPORT, PERTINENT DOCUMENTS
(Nature of the information, as limited as possible)

For the purpose of: **COLLATERAL INFORMATION**
(Purpose of Disclosure, as specific as possible)

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 the Health Insurance Portability and Accountability Act, (HIPPA), 45 CFR Parts 160 & 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 at any time, except to the extent that action has been taken in reliance on it (e.g., probation, parole, etc.), and that in any event this consent expires automatically expire on:

Ninety (90) days from discharge date
(Date or condition of expiration)

FEDERAL LAW AND REGULATIONS DO NOT PROTECT ANY INFORMATION ABOUT SUSPECTED CHILD ABUSE OR NEGLECT FROM BEING REPORTED UNDER STATE LAW TO APPROPRIATE STATE OR LOCAL AUTHORITIES. (*See 42 U.S.C., 290ee for Federal laws and 42 CFR, Part 2 for Federal Regulations*)

_____ I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will.

_____ _____
Client Signature Date

_____ _____
Witness Signature Date