ADDICTION & ABUSE RECOVERY COACHING-Privacy Authorization Form

1. I_____(client name) authorize RUSTY NOKES _____ _____(service provider name) to use and disclose the private information described below (see number 3) to _____

_____(individual seeking the information).

2. Effective Period

This authorization for release of information covers the period of:

a. From _____(date) to ____as needed_____(date).

***OR**

b. __ all past, present, and future periods.

3. Extent of authorization

a. ____ I authorize the release of my complete record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. ____ I authorize the release of my complete health record with the exception of the following information:

__ Mental health records

__ Communicable diseases (including HIV and AIDS)

__ Alcohol/drug abuse treatment

__ Other (please

specify):_____

This private information may be used by the person I authorize to receive this information for medical or other treatment or consultation, billing or claims payment, or other purposes as I may direct. I understand that I have the right to revoke this

authorization in writing at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my coaching, care, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be private or protected.

Client name
(Print):_____

Client
Signature:_____Date_____