*H.A.L.O. Educational Systems, LLC.*

Helping All Learn Options

Canaan, New Hampshire 03741 Phone : (603) 359-3321 Fax (603) 523-8804

**CONSENT/AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION**

I, (Client) DOB authorize **H.A.L.O. Educational Systems, LLC**. to disclose to obtain from

( Person) (Agency)

(Address)

PHONE ( ) EMAIL: @

**(Name or Title, Address and Phone Number of the Person or Organization to which the Disclosure is to be made or received**

the following information: (Please Initial each Consent)

Attendance in treatment Social/Family History

|  |
| --- |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

|  |
| --- |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

Course and results of treatment History of Medical treatment

Treatment plan History of Psychiatric treatment/ Counseling

Treatment recommendations/Aftercare plan Medical history (including medication history)

Discharge plans/Discharge summary Drug/Alcohol test results

Substance use history Biopsychosocial Assessment

Diagnostic summary and diagnoses Substance abuse Evaluations and recommendations

Legal History Physical Exam/TB test

Other (please specify)

The purpose or need for the disclosure authorized herein is to: *(provide integrative treatment approach)*

**(Purpose of disclosure, as specific as possible)**

I understand that my alcohol/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 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 upon it. If not previously

revoked, this consent expires automatically as follows:

*(One Year from the date of signature)*

**(Specifications of the date, event, or condition upon which this consent expires)**

I understand that generally my treatment may not be conditioned on whether I sign a consent form. I have read this release and understand its contents.

*Signature of Client Date*

*Signature of Witness / Counselor Date*