Dr. JiJi's Integral Health Center, LLC.
Authorization for Release of Information

I, Name:_____DOB:_____
(Last, First Middle or Initial)

Employee: _____ Volunteer:_____Intern:_____

Provide consent for the

_____

and the _____

_____to exchange the following information: (check which applies) ___Results of Assessment, _____Verification of Admission, ___Treatment Progress Assessments, ____Discharge Notification, ___Monthly Case Plan Reports, ___Court information, ___Medical records, ____Medical History, ____Other (specify).

The purpose of the release is (check what applies):
____Verification of Compliance with treatment, Monitoring Client progress, _____ADAP as well as internal and external monitoring, _____Coordination of Services, ___Coordinate with Legal Representative, ____Other (specify). _____

I also agree for this form to be transmitted via ____fax, __email/mail___verbal__and/or hand delivered.

I realize that I have the right to revoke this consent prior to its expiration, except in the case that I have been legally mandated into substance abuse/addiction services by one of the parties specified in this consent. If one of the parties specified in this consent is a Criminal Justice System entity that mandated services, this consent will remain in effect until such time that the date or condition or event of expiration occurs. Unless otherwise revoked, this consent will expire on (specify date or condition or event):

_____

Client Signature: _____

Signature of Parent/Guardian: _____
Signature of Clinician: _____

This agreement will also comply and abide by all and any State of Arkansas and Federal regulations Governing Confidentiality and Drug Abuse Patient Records, 42 CFR part 2 as well as the HIPAA: Health Insurance Portability & Accountability Act of 1996, 45 CFR Parts 160 and 164.