Reintegration Scattered Site Referral Packet

Fairview Recovery Services helps people with the disease of alcoholism, chemical dependency, and co-occurring conditions live independent, healthy, and productive lives by providing a continuum of individualized services and care.

REINTEGRATION SCATTERED SITE
REFERRAL PACKET
TABLE OF CONTENTS

Fairview Recovery Services

Administration

Residential Reintegration & Rehabilitation Program

Reintegration Scattered Site

Shelter + Care

Career Choices Unlimited

5 Merrick Street
Binghamton, NY
13904
607-722-8987
Fax: 607-352-4777
fairview@frsinc.org
www.frsinc.org

Addiction Stabilization Center
247 Court Street
Binghamton, NY
13901
607-722-4080
Fax: 607-723-1858

To the Referred Person and the Referral Source,

In order for your referral to be accepted and processed the following documents are needed :

1. An admission packet that has been entirely completed and reviewed by both the referred person and the referral source. This can be found on the Fairview Recovery Services website at: www.frsinc.org or we will be happy to mail one to you. Feel free to make copies to keep on file.

2. A recent psychosocial (within the last year) that must include a substance use disorder diagnosis, and where applicable, a mental health diagnosis.

3. Documentation of a negative PPD/Mantoux test for TB (tuberculosis) within the past year.

4. A complete history and physical from a health care provider completed within the last year, including lab (blood) work with a CBC Count; urinalysis.

5. Proof of funding from DSS or Social Security; Release for funding source. Documentation of Congregate Care level 2 form from funding county.

6. Copy of NYS Benefit Card

7. Current medication list

Please check all that apply: ☐Pregnant Intravenous Substance User
☐Pregnant Substance User ☐ Other who injects drugs
☐Parent/Guardian of child(s)in risk of entering foster care
☐Recently released from criminal justice setting ☐Other substance user

To All Internal Applicants: The Reintegration VOC/ED Agreement must be completed and signed by the Career Choices Unlimited VOC/ED Coordintaor, Residential Case Manager, and Applicant Prior to submitting this packet.

Referrals that are **not** complete will **not** be processed until the above named components are received.

Thank you,
Reintegration Scattered Site Program

Fairview Recovery Services, Inc.

Referral/Admission Packet Checklist

Client Name: _____

Client referral packet should contain all of the following:

- o Homeless documentation
- o 2-way consent between referring agency and FRS 2-
- o way consent between funding source and FRS
- o Fairview Recovery Services Counselor
- o Questionnaire Client Introduction
- o Fairview Recovery Services Client Questionnaire
- o Application for Reintegration Program LOCADTR
- o Release TRS-62 LOCADTR Assessment
- o

In addition to the referral packet, please be sure to include the following information:

- o A recent psychosocial within the past year; must include a SUD diagnosis, and where applicable, a mental health diagnosis
- o Documentation of PPD/Mantoux test within the past year
- o Complete history and physical within the past year
- o Complete blood count (CBC) within the past year
- o Urinalysis results within the past year
- o An up-to-date list of current medications prescribed
- o Copy of NYS Benefit Card
- o **Proof of funding from funding source**

Please place a check in the boxes below next to the items you are sending in conjunction with this admission packet.

Please return this form with the referral packet to Fairview Recovery Services with all completed information.

REVOKED ON_____ Staff sig_____

MULTIPARTY CONSENT FORM FOR THE RELEASE OF CONFIDENTIAL INFORMATION CONCERNING ALCOHOLISM/DRUG ABUSE PATIENT

PATIENT'S LAST NAME, FIRST, M.I.	
DOB	
FACILITY **Broome County Dept. Social Services**	UNIT **Chemical Dependency Services Unit** **Phone: 607-778-1251/1253**

I, _____, authorize the following Broome County OASAS/OMH licensed programs
(NAME OF PATIENT)

Addiction Center of Broome County programs, UHS/New Horizons Chemical Dependency Treatment programs, UHS Outpatient Mental Health Clinic, Fairview Recovery Services programs, Family & Children's Society/Family Counseling Services programs, and Helio Health/Binghamton Evaluation Center, Cornerstone Family Healthcare

To disclose the following information to Broome County Social Services at 36-42 Main St Binghamton, NY 13905:

EXTENT OR NATURE OF INFORMATION TO BE DISCLOSED/RELEASED
Evaluation results and recommendations, dates of service, diagnosis/brief description of progress/prognosis, medical history, medical tests and procedures to include urine drug screen results, psychiatric/psychological consults, psychosocial/diagnostic summary, legal history, and discharge summary.
PURPOSE OR NEED FOR DISCLOSURE/RELEASE
To monitor compliance with Chemical Dependency treatment for Temporary Assistance Applicants/Recipients as a NYS Office of Temporary and Disability Assistance mandate.

I, the undersigned, have read the above and authorize the staff of the disclosing/releasing facility named to disclose/release such information as herein contained. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure/release is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Pts. 160 &164; and that re-disclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part.

Time period, event or condition replacing period specified above: 2 years

NOTE: Any information released through this form will be accompanied by the form prohibition on Re-disclosure of Information Concerning Alcoholism/Drug Abuse Patient (TRS-1)

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

X_____ _____
(Signature of Patient) (Signature of Witness)

_____ _____
(Print Name of Patient) (Signature of Parent /Guardian when required)

X_____ _____
(Date) (Date)

Congregate Care Level II Referral Authorization Form

Broome County Department of Social Services/Chemical Dependency Services Unit
36-42 Main St Binghamton, NY 13905 Phone: 607-778-1253/1251
Email: colleen.oneil@dfa.state.ny.us or **Fax: 607-778-1254**

PLEASE NOTE: DO NOT SUBMIT FORM UNTIL TEMPORARY ASSISTANCE APPLICATION IS SUBMITTED TO DSS ~ EXPECT AT LEAST 48 HOUR TURNAROUND TIME FOR OUR RESPONSE.

Date: _____ ***Name & Address of referral source or facility making the level of care recommendation:***

_____

Phone #: _____***Fax#***_____

Client Name: _____ **DOB:** _____ ***SS#***_____

Check specific CCII program you are requesting approval for:

☐**Broome County Program:** _____

☐**Outside of Broome County Program: (**Name, address, phone & fax#)_____

_____

Level of Care: ☐**820 Stabilization** ☐**Residential Rehab** ☐**Reintegration** ☐**Community Residence** ☐**Supportive Living** ☐**Intensive residential** ☐**Other**_____

Brief Summary of History and Diagnosis: (may attach psychosocial hx and/or LOCADTR)
(Include information regarding client's current condition and history)

FOR TREATMENT OUTSIDE OF BROOME COUNTY: ***Clearly describe a clinical reason why this level of care cannot be accomplished in Broome County. This must be stated by the clinician (not the patient):***

Name of Licensed/Credentialed Provider: **Print**_____

Signature: _____

BCDSS/CDSU CLINICAL APPROVAL – No payment from DSS will occur unless approval is granted.
THIS FORM DOES NOT SERVE AS A GUARANTEE OF PAYMENT.

☐**APPROVAL** ☐ **DENIAL (Future requests must be resubmitted)**

Signature of Broome County DSS District CASAC**:** _____ Date: _____

☐**ACTIVE TA CASE OR PENDING APPLICATION** ☐**NO ACTIVE TA CASE OR APPLICATION ON FILE**

Signature of BCDSS/CDSU Caseworker when needed: _____

Fairview Recovery Services, Inc.
Reintegration Scattered Site Program
Funding Page

-If client receives their funding from Broome County, pg. 5 & 6 needs to be completed and faxed to Broome County CDSU. Once CDSU returns pg. 6, that copy needs to be faxed to the Admissions Coordinator @ 607-352-4777

-If client receives their funding from out of county, Admissions Coordinator needs written documentation from their county for approval of funding for the Reintegration program.

-Once the coordinator receives funding approval and completed referral packet, client will be added to wait list at that time.

-If packet is faxed without funding approval, the client will NOT be added to the wait list until documentation has been received on funding approval for Reintegration.

Any questions about this process, please contact FRS Admissions at (607) 722-8987 ext. 331

FAIRVIEW RECOVERY SERVICES, INC.

Patrick Haley, LMSW
Executive Director

REHABILITATION CENTER FOR WOMEN
REHABILITATION CENTER FOR MEN
REINTEGRATION

5 Merrick Street
Binghamton, NY 13904
Phone (607) 722-8987
Fax (607) 352-4777

STABILIZATION CENTER
247 Court Street
Binghamton, NY 13901
Phone (607) 722-4080
Fax (607) 723-1858

Dear Referring Agency,

As a requirement, the "**Client Homeless Status: Eligibility Documentation**" form has been added to our referral packet. If the individual you are referring is not homeless, please indicate that next to the client's name on the form and sign it.

If the individual is homeless, please check the box that describes the individual's situation and attach supporting documentation to the form.

Examples of supporting documentation can be found in the second column on the form. If you are in need of additional assistance, or have any questions regarding requirements, please feel free to contact our Reintegration Coordinator (607) 722-8987 ext. 233 or Admissions Coordinator at (607) 722 8987 ext. 331.

Thank you for your cooperation with requirements.

Sincerely,

Patrick Haley, LMSW
Executive Director

CLIENT HOMELESS STATUS: ELIGIBILITY DOCUMENTATION

Client Name: _____ Date of Intake: _____

Check the current status and attach the appropriate documentation to verify homelessness eligibility.

Homeless Status	Type of Documentation	Documentation Attached
Living on the street	A signed and dated general certification from an outreach worker verifying that the services are going to homeless persons, and indicates where the persons served reside.	
Persons living on the street Persons coming from living on the street (and into a place meant for human habitation)	Staff should provide written information obtained from third party regarding the participant's whereabouts, and, then sign and date the statement.	
Persons coming from an emergency Shelter for homeless persons	Written referral from the agency.	
Persons coming from transitional housing for homeless persons	Written verifications to include residency and homeless status prior to program entry.	
Persons being evicted from a private dwelling	Documentation of income, efforts to obtain housing, why participant would be on street, and either documentation of formal eviction proceedings or statement from family evicting participant. (not eligible for acceptance directly into PH from 2005 awards onward.)	
Persons from a short-term stay in an institution who previously resided on the street or in an emergency shelter	Written verification from the institution's staff that the participant has been residing in the institution for less than 31 days, and information on the previous living situation.	
Persons being discharged from a longer stay in an institution	Written verification from the institution of discharge within one week of accepting client into SHP/S+C program AND documentation of income, efforts to obtain housing, and why person would be homeless without assistance.	
Persons fleeing domestic violence	Written, signed and dated verification from the participant.	
Other:	Written verification from client or referring agency.	
CHRONIC HOMELESSNESS Single, disabled Adult + Continuously homeless for 1 yr or more OR.. 4 episodes of homelessness in the past 3 years with total accumulation of homelessness periods equaling 12 months or more. (streets/shelters)	Written verification from outreach workers, shelters AND brief, written statement regarding previous shelter/street stays (dates, locations) AND – documentation of disability	

NOTES:

STAFF MEMBER: _____ Date: _____

CLIENT: I verify this information is true & accurate. I confirm that I have been or am about to be homeless.

_____ Date: _____

Signature of Client

FAIRVIEW RECOVERY SERVICES, INC.

RESIDENTIAL REINTEGRATION &
REHABILITATION PROGRAM
REINTEGRATION SCATTERED SITE
CAREER CHOICES UNLIMITED
5 Merrick Street
Binghamton, NY 13904
Phone (607) 722-8987
Fax (607) 352-4777

Patrick Haley, LMSW
Executive Director
5 Merrick Street
Binghamton, NY 13904
Phone (607) 722-8987
Fax (607) 722-4777

ADDICTION STABILIZATION CENTER
247 Court Street
Binghamton, NY 13901
Phone (607) 722-4080
Fax (607) 723-1858

2-WAY CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Social Security Number: _____ Date: _____

I, _____, hereby authorize and consent to

communication **BETWEEN** Fairview Recovery Services Inc. and

_____

(Agency Name, Full Address, Phone Number)

_____ (or his/her successors).

(Name & Title of a Contact Person)

The extent of information to be disclosed **Medical history, laboratory results, physical; psychosocial evaluation & recommendations; psychiatric evaluation; diagnosis; treatment history; progress in treatment; discharge summary & discharge status.**

The purpose of the disclosure authorized herein is to: **Coordinate treatment and share pertinent information for this purpose.**

I, the undersigned, have read and authorized the staff of the disclosing facility name to disclose such information as herein contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. This consent shall expire 6 months from its signing, unless a different time period, event or condition is specified below, in which case such time period, even or condition shall apply. I also understand that any disclosure is bound by Title 42 of the Code of Regulations governing the confidentiality of alcohol and drug abuse patient records and that re-disclosure of this information is forbidden without written authorization on my part.

Time period, event or condition replacing period specified above: _____

Note: Any information released through this form will be accompanied by Form A-4400 Prohibition on Re-disclosure of Information Concerning Alcoholism/Drug Abuse Patient.

_____ _____
Patient Signature Witness Signature

_____ _____
Patient Name (Printed) Witness Name (Printed)

_____ _____
Date Date

Fairview Recovery Services, Inc.
Counselor Questionnaire

Client Name: _____

Thank you for taking time to help us evaluate your client for placement into Fairview Reintegration Program. Your answers to all of the following questions are critical to our assessment of your client's appropriateness for admission to our facility.

1. Why do you feel that your client has the ability to remain clean and sober outside of a community residence?

   _____
   _____
   _____
   _____

2. Please tell us your impressions of your client's current denial system.
   Please circle the most appropriate number:

No Denial	Moderate Denial	High Denial	Extreme Denial
1	2	3	4

3. In what areas has your client made the most progress in treatment?

   _____
   _____
   _____
   _____

4. In what specific areas will your client need the most encouragement and support if admitted to FRS Reintegration Scattered Site Program?

   _____
   _____
   _____
   _____

5. It can be a challenge for people in early recovery to live in close contact and harmony with others. Please describe if your client will benefit from peer support:

   _____
   _____
   _____
   _____

6. Please add any additional information that will help us help your client: _____

   _____
   _____
   _____

Thank you for spending the time to help your client through this referral process.

_____ _____

REFERRING AGENT DATE

Client Introduction

Thank you for applying to Fairview Recovery Services Reintegration Scattered Site Program. Fairviews Reintegration is a program for the recovering individual struggling with SUD. Our Reintegration program is a scattered site apartment setting. Program participants will be sharing a two-bedroom apartment with another individual in Reintegration. Clients share the responsibility for basic activities of daily living (i.e. housekeeping). Each apartment is furnished with bedroom furniture, living room furniture, kitchen table and chairs, and essential household items. Clients are responsible for providing their own bed linens and bathroom towels, personal hygiene and cleaning products.
(Cable service not included).

We will develop an individualized Recovery Plan (i.e. Alcohol and Drug, Mental Health, Marital/ Family, Social, Educational/Vocational/Employment, Health and Legal), with you within fourteen days (14) of admission to Reintegration, with input from the referral source and client. Length of stay is based on an individual's progress and need for continued services.

To help us know you better, we ask you to fill out the accompanying forms in a **thorough and honest manner.**

All information will be treated confidentially. If you are accepted into Fairviews Reintegration Program, all information supplied by yourself, your primary counselor, and your current treatment agency will be part of your permanent record and will be referred to throughout your stay at Fairview.

After we receive all of this information, from you and your counselor, your counselor will be notified of your appropriateness as a candidate for our Reintegration Scattered Site Program. Your admission will be prioritized in conjunction with the waiting list policy in compliance with the NYS OASAS guidelines.

Again, thank you for applying for residence at Fairview Reintegration Scattered Site Program.

Fairview Recovery Services, Inc.
Client Questionnaire

Client Name: _____

1. Please tell us your impressions of where you are at in treatment at the present time. What have you gained? What do you need to work on in treatment:
_____
_____
_____
_____
_____

2. This Reintegration Program provides a safe, sober living environment. Why are you seeking to live in this type of environment at this time?_____
_____
_____
_____

3. There will be other people living in Fairviews Reintegration program who are also in early recovery. How will you add to the quality of recovery in the Reintegration Community?
_____
_____
_____
_____

4. What are your personal assets and your personal liabilities in this phase of your recovery?
_____
_____
_____
_____
_____

5. What are you willing to do specifically in the area of self help, continuing treatment and personal growth during the next 4-6 months?_____
_____
_____
_____
_____

6. Do you have a court case pending? _____ If yes, are you facing jail time? _____
If yes, explain_____
_____
_____
_____

7. Have you ever been treated for mental illness? _____ If yes, explain: _____
_____
_____
_____

CLIENT QUESTIONAIRE, CONTINUED NEXT PAGE

8. Do you have a learning disability? _____ If yes, explain: _____
_____
_____
_____

9. Have you ever sexually abused a minor? _____

10. Have you ever been convicted of arson? _____

11. Have you ever been in jail or prison? _____ If yes, how many different times? _____
How much total time have you spent in jail or prisons? _____

12. Do you have any medical problems? _____ If yes, explain: _____
_____
_____
_____

13. In the past 12 months has anyone hit, slapped, pushed, punched or kicked you? If yes who?
_____
_____
_____
_____
_____

14. Have you hit, slapped, pushed, punched or kicked anyone in the past 12 months? If yes, who?
_____
_____
_____

15. What is your level of contact or involvement on an ongoing basis with the person named above?
_____
_____
_____

16. Do you have a current order of protection in place against someone else or against you? If yes, against or by whom? Through what court?
_____
_____
_____

17. In the event you relapse, or leave the Reintegration program, who can you stay with?

Name: _____

Address: _____

Phone: _____

_____ _____
Signature of Client Date

Application for FRS Reintegration Scattered Site Program

Name: _____ Case Manager: _____

Soc. Sec. #: ____-____-_____ Date of Birth: ____/____/_____

Admission Date to Reintegration: _____

Sobriety Date: _____

Where and when did last relapse occur: _____

_____

Please list all treatment and/or residential placements you have completed in the last 6 months.

_____ _____

_____ _____

_____ _____

Are you presently in treatment? Where? Name of treatment counselor?

_____

Do you currently attend a 12 step program? _____

On average how many meetings do you attend weekly? _____

Do you have a home group? _____

Do you work with a sponsor? _____

Have you developed a sober support system? _____

Do you have Vocational/Educational goals? _____

_____

Are you prescribed any current medications (Including MAT and or MH medications)?

_____

_____

_____

If prescribed medications, who is your current prescriber?

_____

_____

FAIRVIEW RECOVERY SERVICES, INC.
Fairview and New Outlook Residential Rehabilitation
Reintegration
Addiction Stabilization Center
5 Merrick Street, Binghamton, NY 13904

Consent for Release of Information Concerning Patient

Instructions: Prepare one (1) copy for patient's case record. If this form is used for billing purposes, prepare additional copy for Patient Resources Office. If this form is sent to another agency for information, prepare a second copy for patient's case record.

Patient Name: _____
Last First MI

DISCLOSURE WITH PATIENT'S CONSENT

Extent or nature of information to be disclosed: _____

_____

Purpose or need for the disclosure: _____

_____

Between name of person or organization disclosing information:

_____

And name of the person or organization to which the disclosure is being made:

_____

I, the undersigned, have read the above and authorized the staff of the disclosing facility name to disclose such information as herein contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. This consent shall expire 6 months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure is bound by Title 42 of the Code of Regulations governing the confidentiality of alcohol and drug abuse patient records and that re-disclosure of this information is forbidden without written authorization on my part.

Time period, event or condition replacing period specified: 6 months from date of discharge

Note: Any information released through this form will be accompanied by Form A-4400 Prohibition on Re-disclosure of Information Concerning Patient.

_____ _____ _____ _____
Patient Signature Date Signature of Parent/Guardian when required Date

_____ _____
Patient Name (Printed) Parent/Guardian Name (Printed)

REINTEGRATION SCATTERED SITE

What to Pack for Your Stay

For your convenience, please use this checklist as you prepare for your stay at our facility.

Please bring only items identified on the list below.

Upon Admission all Clients are expected to bring:

● Linens ● Towels ● Personal Hygiene & Cleaning Supplies

***** 3 BAG LIMIT PER CLIENT *****

Clothing:

The amount of clothing is to not exceed 2 bags. Please have weather appropriate clothing and plan to switch out clothing as the seasons change. Items FRS suggests having is as follows:

☐Shirts/Blouses
☐ Pairs Jeans/Pants/Skirts in Combination
☐Underwear/Socks/Bras
☐Pajamas/Robe/Slippers
☐Outer Set (coat/jacket, gloves, hat, boots)
☐Sneakers

Toiletries:

☐Shampoo
☐Deodorant
☐Soap
☐Toothbrush
☐Toothpaste
☐Washcloths
☐Towels

Bedding:

☐ (Full-Size Bed in most apartments)
☐Sheets/Pillowcases
☐ Pillows
☐Blanket
☐Comforter

Other:

☐Notebook, Stationary, Stamps, Pens
☐Appropriate Books, Novels and Magazines
☐Family Photo
☐Laundry detergent
☐Basic household cleaning supplies; dish detergent, bathroom cleaner, kitchen cleaner, etc.

****No air conditioners or space heaters allowed in the apartment****

~~~~~~

FAIRVIEW RECOVERY SERVICES PROVIDES:
BASIC HOUSEHOLD ITEMS AND FURNITURE.

REINTEGRATION IS A TEMPORARY LIVING SITUATION.
CLIENTS ARE NOT PERMITTED TO BRING IN:
FURNITURE AND/OR HOUSEHOLD ITEMS.

ONLY THE ABOVE ITEMS ARE PERMITTED
TO BE BROUGHT INTO THE APARTMENTS.
~~~~~~

NEW YORK STATE
OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

CONSENT TO RELEASE OF INFORMATION CONCERNING ALCOHOLISM/DRUG ABUSE PATIENT
LOCADTR ASSESSMENT

Revoked On: _____ Staff Initials: _____

Patient's Last Name	First	M.I.
Case Number		
Facility	Unit	

INSTRUCTIONS: **GIVE A COPY OF THIS FORM TO PATIENT!** Prepare one (1) copy for the patient's case record. If this form is to be sent to another agency with a request for information, prepare an additional copy for the patient's case record.

PATIENT'S CONSENT TO DISCLOSE AND OBTAIN PERSONAL IDENTIFYING INFORMATION

EXTENT OF NATURE OF INFORMATION TO BE DISCLOSED OR OBTAINED:

All information necessary to complete a personalized Level of Care for Alcohol and Drug Treatment Referral "LOCADTR" assessment.

PURPOSE OR NATURE FOR DISCLOSURE/RELEASE AND NAME OF ORGANIZATIONS DISCLOSING AND OBTAINING PERSONAL IDENTIFYING INFORMATION:

I consent to the disclosure of confidential information to, and among, the New York State Office of Alcoholism and Substance Abuse Services (OASAS), the OASAS-Certified treatment facility identified above, and Payer / Managed Care Plan _____ _____ of my clinical treatment including information from the OASAS Client Data System (CDS) and my Social Security Number.

I understand that the level of care determination assessment will only be shared with me, the OASAS treatment facility, and Payer / Plan identified above. Unless I have given written permission to share the information with other agencies, programs or payers.

I further understand that non-personal identifying information may be evaluated so that the effectiveness of the LOCADTR assessment tool can be evaluated.

I, the undersigned, have read the above and authorize the New York State Office of Alcoholism and Substance Abuse Services and the staff of the OASAS-certified treatment facility named above to disclose and obtain such information as herein specified.

I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire within six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure of any identifying information is bound by Title 42 of the Code of Federal Regulations (C.F.R.) Part 2, governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. §§160 &164; and that redisclosure of this additional information to a party other than those designated above is forbidden without additional written authorization on my part.

NOTE: Any information released through this form **MUST** be accompanied by the form **Prohibition on Redisclosure of Information Concerning Alcoholism / Drug Abuse Patient** (TRS-1)

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form.

_____ (Signature of Patient)

_____ (Signature of Parent/Guardian)

_____ (Print Name of Patient)

_____ (Print Name of Parent/Guardian)

_____ (Date)

_____ (Date)