RELEASE OF INFORMATION

SEQUOIA
detox centers

PATIENT INFORMATION

FIRST NAME: ______________________________ LAST NAME: __________________________

BIRTHDATE: ____ /____ /________ PHONE NUMBER: _______ - _________ -______________

FIRST PARTY

INDIVIDUAL/ COMPANY NAME	ADDRESS	PHONE NUMBER	EMAIL/FAX NUMBER

SECOND PARTY

INDIVIDUAL/ COMPANY NAME	ADDRESS	PHONE NUMBER	EMAIL/FAX NUMBER
Sequoia Detox Centers	10305 E Montgomery Drive	(509) 418-2108	sequoia.help@sequoiadetoxcenters.com
	Spokane Valley, WA 99206		(509) 315-9386

- ☐ RELEASE INFORMATION FROM 1ST PARTY TO 2nd PARTY
- ☐ RELEASE INFORMATION FROM 2ND PARTY TO 1ST PARTY
- ☐ MUTAL SHARING INFORMATION BETWEEN 2ND PARTY AND 1ST PARTY

INFORMATION TO RELEASE/RECIEVE

____
PATIENT INITIALS

All information in record including, but not limited to history, diagnosis, progress in and/or response to treatment and prognosis.

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PATIENT INITIALS

All information in record *EXCLUDING*:

- ☐ Information relating to my HIV, AIDS, or STD status
- ☐ Evaluation Results
- ☐ Treatment Recommendations
- ☐ Discharge Summary
- ☐ Progress Notes
- ☐ Medication Information
- ☐ Group Notes

☐ Other____

REASON TO RELEASE/RECEIVE INFORMATION

☐ Evaluation ☐ Treatment/discharge planning ☐ Coordination of care

EXPIRATION OF DOCUMENT

This release of information is valid for *90 days past the date of discharge* from Sequoia Detox Centers; or by the date, event, or condition specified below:

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PATIENT AUTHORIZATION

I authorize the receipt or release of psychiatric records, mental health records, drug and alcohol records and HIV/STD related information as applicable. I understand that my records are protected under the Federal/State confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that my consent is subject to a written revocation by me at any time except to the extent that action has been take in reliance on it (e.g. court related, probation, parole, etc.)

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 CFR pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided by 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 and that in any event, this consent expires automatically as described above unless further release is authorized by law.

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

PRINTED NAME OF PATIENT ______________________ DATE ______________

PATIENT/LEGAL GUARDIAN SIGNATURE ______________________ INITALS OF STAFF ______________

This notice accompanies a disclosure of information concerning a patient in alcohol/drug treatment, made to you with the consent of such patient. This information has been disclosed to you from records protected by federal confidentiality rules, 42 Code of Federal Regulations (CFR), Part 2.

The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person of whom it pertains or as otherwise permitted by 42 CFR, Part 2.

A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.