

Patient Name _____

Date of Birth _____



Fairbanks
Experts in addictions. Focused on recovery.

8102 Clearvista Parkway Indianapolis, IN 46256
(317) 849-8222

CONSENT FOR MUTUAL DISCLOSURE

I authorize the release/exchange of my records and information between **FAIRBANKS** and

Name

Address and Zip Code

Phone

USE CHECK MARK ONLY

OBTAIN DISCLOSE

- Presence in and Discharge from Treatment
- Assessment Data (Initial Screening/Recommendations, Psychosocial)
- Medical/Nursing Information (History and Physical, Psychiatric Evaluation, Psychological Evaluation
Nursing Assessment, Medical Screening, Dental Records, Immunization Records, Physician Orders, Vital
Sign Records, Medication Administration Records, Medical Discharge Summary)
- Medical Recommendations to Healthcare Providers for treatment and ongoing management
of narcotics and addictive substances
- Clinical Information (Flow sheets, Progress Notes/Reports, Treatment Plan, Recovery Plan, Counselor
Discharge Summary)
- Diagnostic Test Results (Laboratory, X-Ray, EKG, Portable Breath Test [PBT], UDS)
- Information Pertaining to Communicable Diseases, including HIV/AIDS
- Medication Reconciliation Forms
- Other _____

Purpose for Mutual Disclosure:

- Data gathering
- Visitation
- Other _____
- Diagnosis & Evaluation
- Assessment/Treatment Planning
- Discharge/Continuing Care Planning
- Family Involvement in Treatment

Mode of Disclosure:

Unless requested in writing that a disclosure be made in a specific format, Fairbanks reserves the right to disclose information in the most appropriate format, as permitted by this authorization and in accordance with applicable law. This includes, but is not limited to verbal, written, electronic, e-mail or facsimile.

Revocation of Consent:

Unless sooner revoked, this consent expires upon the following event, date, or condition _____.
If none are specified this consent will expire one year from the date signed.

I understand that information regarding my treatment is protected under the Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2, and 45 CFR Part 160 & 164 (HIPAA). This information cannot be disclosed without my written consent unless otherwise provided by law. I further understand that this consent is subject to revocation at any time except to the extent that information has been released in reliance there on, including provision of treatment services in reliance on a valid consent to disclose information to a third party payer. Fairbanks shall not be liable to the undersigned for any consequences resulting from this disclosure.

Signature, Patient

Date

Signature, Parent/Guardian

Date

Signature, Witness

Date

FOR COMPLETION BY COUNSELOR: *IF REQUESTED*, release the following information: Medical Discharge Summary Counselor Discharge Summary Recovery Plan Other _____

FOR COMPLETION BY MEDICAL RECORDS: The following information was released on _____ by _____

