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

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
[ ]	[ ]	Legal/Court Documents (including court orders, placement agreements)
[ ]	[ ]	Information Related to Billing (including face sheet, insurance card, itemized statement, billing arrangements, explanation of benefits and payment options)
[ ]	[ ]	Other_____

* Medical discharge summary contains laboratory and other diagnostic data

Purpose for Mutual Disclosure:

[ ] Data gathering [ ] Diagnosis & Evaluation [ ] Discharge/Continuing Care Planning
[ ] Visitation [ ] Assessment/Treatment Planning [ ] Family Involvement in Treatment
[ ] Billing of and/or Communication with Third Party Payers [ ] Personal
[ ] Other _____

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.

If the consent is for billing of and or communication with Third Party Payers, this release shall remain active until which time as the claim has been settled with the third party payer.

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