HUTHER DOYLE

where addiction recovery changes lives

160 East Avenue
Rochester, NY 14605
(585)325-5100

803 West Avenue
Bldg. 2, 2nd Floor
Rochester, NY 14611

Client Name: _____
(Last) (First) (Middle Initial)

Date Of Birth: _____

Extent or nature of disclosure is limited to:

___ Psychosocial Assessment	___ Substance Use History	___ Diagnosis
___ Psychiatric Evaluation	___ Treatment History	___ Client Status
___ Psychological Evaluation	___ Progress Notes	___ Recommendations
___ Medical History	___ Discharge Summary	___ Dates in Program
___ Medication Record	___ Academic Performance	___ Legal Status
___ Laboratory Reports	___ DMV Form (DS-449)	___ Other: _____

Purpose for disclosure is:

___ Evaluation, Treatment Planning, Continuity of Care ___ Referral

___ Benefit Certification (DSS, SSI, Medicaid, etc.) ___ Other: _____

___ Resolution of Legal Issues (Court, Probation, Parole)

Permission is hereby given to Huther-Doyle to:

___ Release information to: _____

OR

___ Obtain information from: _____

I, the undersigned, have read the above and authorize staff at the facility named to disclose such information as indicated. I understand that the disclosure is bound by Title 42 of Federal Code governing the Confidentiality of Alcohol and Drug Abuse Records 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 for in the regulations. I also understand that re-disclosure of this information to any party other than indicated above, is prohibited without additional written authorization by me. I understand that this consent may be withdrawn by me, with written notice, at any time except to the extent that action has already been taken.

Expiration Date: _____

I understand that generally Huther-Doyle 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.

Client Signature _____ Date ___/___/___ Witnessing Signature _____ Date ___/___/___

I hereby cancel my authorization to release the information outlined on this form.

Client Signature _____ Date ___/___/___ Witnessing Signature _____ Date ___/___/___