

**CONSENT FOR THE RELEASE OF CONFIDENTIAL
ALCOHOL OR DRUG TREATMENT INFORMATION
TO AND FROM CHILD WELFARE AGENCY
(AND COURT AND ATTORNEY (S), WHERE NECESSARY)**

I, _____, authorize (1) [The ABC Alcohol and Drug Treatment Program],
(Name of patient) (Name or general designation of program making disclosure)
and (2) [The Bay Child Welfare Agency] employees assigned to my family, and (3) [The Bay County Family Court],
(Name of the child welfare agency) (Name of the appropriate court)
and (4) [Jane Smith], and (5) [Betty Brown],
(Name of the patient's attorney) (Name of child(ren)'s attorney (law guardian(s)))

to communicate with and disclose to one another the following information:
(Nature and amount of the information as limited as possible)

[initial each category that applies]

- ___ my name and other personal identifying information;
- ___ my status as a patient in [alcohol and/or drug] treatment;
- ___ initial evaluation;
- ___ date of admission;
- ___ assessment results and history;
- ___ summary of treatment plan, progress and compliance;
- ___ attendance
- ___ urinalysis results;
- ___ changes in address, household composition or personal relationships that could result in child neglect/abuse or domestic violence;
- ___ observations of visitation of children;
- ___ discharge plan;
- ___ date of discharge and discharge status;
- ___ other: _____

The purpose of the disclosures authorized in this consent is to: (purpose of disclosures, as limited as possible)

provide the [Child Welfare Agency], [Family Court], [child(ren)'s attorney (law guardian(s)) and [my attorney] with the information they need to determine whether I have made sufficient progress in treatment so as to [retain] [regain] custody of my child(ren).

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in 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 follows:

[Specify the date, event or condition upon which this consent expires. This could be one of the following:

(1) Upon termination of the child abuse/neglect case and/or investigation against me. OR

(2) Specify earlier date if required by state law.]

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form.

Dated: _____

Signature of patient

Signature of person signing form if not the patient

Describe authority to sign on behalf of patient: _____