Consent for the Release of Confidential Information

I, ____, authorize
(Name of Client)

Substance Abuse Treatment Unit of Central Iowa (SATUCI)
PO Box 1453 / 9 North 4th Avenue
Marshalltown, Iowa 50158
(641)752-5421 / Fax (641)752-7211

to disclose to ____
(Name of person or organization from which disclosure is to be made)

____
(Address)

____
(City, State, Zip)

The following information: ____

____

____

The purpose of the disclosure authorized herein is to:

____

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality 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 in writing 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:

____
(Specification of the date, event or condition upon which this consent expires)

I understand that generally SATUCI 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.

____________________ ____
(Date) (Signature of Client)