Rainforest Recovery Center
BARTLETT REGIONAL HOSPITAL
3250 Hospital Drive Juneau, AK 99801 Phone: 907-796-8690 Fax:907-796-8692

RRC Inpatient Application Packet

Welcome!

Thank you for your interest in Rainforest Recovery Center (RRC).

The items in the checklist below must be completed and submitted with your application. Once completed you may submit it via fax at 907-796-8692, by mail or in person at our front office. All of your information will then be reviewed by our treatment team.

Rainforest Recovery Center will review open legal charges on a case by case basis.

Once your application and assessment are complete and submitted for review, you will receive a phone call regarding the next steps. If we have any additional questions, we will ask you at that time. If you have any additional questions or need assistance with the application, please call our intake staff at 907-796-8690.

Each page must be reviewed, signed, and dated by the applicant in order to be considered for our programs.

Thank you for choosing Rainforest Recovery Center.

The following items are <u>required</u> to be considered for our program:

☐ This Rainforest Recovery Center inpatient application.

☐ Medical Clearance Letter, including history and physical- Completed within the last 30 days by your MD, DO, Nurse Practitioner or Physician Assistant. See medical clearance letter (page 3) for complete list of requirements.

☐ Integrated behavioral health assessment or substance use behavioral health assessment done within the last year. An addendum may be requested.

☐ Signed COVID agreement form (page 2).

Also, please sign our Rainforest Recovery Center Release of Information(ROI, page 13) for your: (1) primary care provider and (2) anyone else who may be involved in your care.

My signature on all the below pages indicates that I have read and understand the rights and responsibilities, facility rules and information, and comments, complaints, and grievance procedures set forth by Bartlett Regional Hospital and Rainforest Recovery Center, and that all my information below is accurate.

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Medical Clearance letter: History and physical

Dear Medical Professional:
Please assist us in determining whether the bearer of this letter is medically capable of participating in a residential chemical dependency treatment program. The program requires participation in sedentary activities involving sustained mental effort as well as intermittent mild physical activity, such as walking, for up to eight hours daily.

A copy of your medical evaluation note is sufficient for this purpose. It would be most helpful if you would include the following information in your note:

- The intoxicating substances for which the patient is seeking residential treatment
- Whether the patient has a history of complicated withdrawal symptoms, such as seizures or delirium tremens
- A list of the patient's chronic medical problems
- Any acute medical problems or current physical complaints
- A current medication list
- A list of food and medication allergies
- Whether the patient can ambulate and transfer without assistance
- Whether the patient is pregnant
- Whether the patient demonstrates gross cognitive impairment
- The results of any lab or diagnostic tests you order or recommend
- A copy of a physical exam completed within the last 30 days

Please note that our facility is not equipped to manage patients who cannot ambulate or transfer without assistance; have severe medical problems such as decompensated heart, liver, or kidney failure; or are unable to care for themselves because of untreated mental illness or major neurocognitive disorder. Stable medical problems and use of ambulatory aids, such as a cane or walker, are acceptable.

Thank you for your assistance,

Sincerely,

Rainforest Recovery Center

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Patient Information

Full Legal Name: _____ SSN: _____ DOB: _____ Age: _____
Preferred Name: _____ Sex at birth: ☐M ☐F Identify as: ☐M ☐F ☐Other
Maiden Name: _____

Contact Information

Physical Address: _____ Home Phone: _____
Mailing Address: _____ Cell Phone: _____
City & State: _____ Work Phone: _____
Employer: _____

May we leave a message identifying RRC on your phone? ☐Yes ☐No

If Applicable: ☐Guardian ☐Payee
Name: _____ Home Phone: _____
Physical Address: _____
Mailing Address: _____ Cell Phone: _____
City & State: _____
Employer: _____ Work Phone: _____

Emergency Contact Numbers:

Name	Home Phone	Work Phone	Relationship to Client

Why are you seeking services at this time? _____
_____
_____

Are you currently? ☐Pregnant ☐IV Drug User ☐HIV/AIDS Positive ☐Co-occurring disorder
- If pregnant what is the due date? ____/____/___ (i.e. In need of mental health/addiction treatment)

What is your drug of choice? _____

What is your goal in treatment? My treatment goal will be: _____
_____

What date are you available to enter treatment? _____

Signature: _____ **DATE:** _____

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Billing Information / Authorization

Expected Payment source (check all that apply) **:**

☐ **Medicaid (*Includes Denali Kid Care)*** ☐ **Other Insurance** ☐ **Self-pay**

Note: If you are uninsured, a financial services counselor is available to assist you. If you mark the self-pay box, we will contact you to discuss payment options. Please ensure you provide us with a current contact number in this application.

Medicaid ID Number: _____

Please provide a copy of proof of coverage from Medicaid.

Insurance (All asterisked information must be completed.
Copy of both sides of insurance Card Enlarge so it is legible when faxed. ☐

*Name of Primary Insurance Company	Subscriber's Employer
*Subscriber (Policy Holder) Name	Insurance Company Address
*Subscriber's ID Number	Insurance Company Phone
*Subscriber's Date of Birth	Group or Plan #
Relationship to Client	Subscriber's Address (if different from above)
	Subscriber's Home Phone (if different)

Copy of both sides of insurance Card Enlarge so it is legible when faxed. ☐

*Name of Secondary Insurance Company	Subscriber's Employer
*Subscriber (Policy Holder) Name	Insurance Company Address
*Subscriber's ID Number	Insurance Company Phone
*Subscriber's Date of Birth	Group or Plan #
Relationship to Client	Subscriber's Address (if different from above)
	Subscriber's Home Phone (if different)

Note: Your insurance will be billed separately for physician services. You may receive a bill from Southeast Physician Services for any balance not covered by insurance.

Thank you again for choosing Rainforest Recovery Center. Your first step to a life free from addiction.

Signature: _____ **DATE:** _____

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RRC COVID Agreement Form:

I acknowledge the contagious nature of the Coronavirus/COVID-19 and that the CDC and many other public health authorities still recommend practicing social distancing.
I further acknowledge that Rainforest Recovery Center has put in place preventative measures to reduce the spread of the Coronavirus/COVID-19.
I further acknowledge that Rainforest Recovery Center cannot guarantee that I will not become infected with the Coronavirus/Covid-19. I understand that the risk of becoming exposed to and/or infected by the Coronavirus/COVID-19 may result from the actions, omissions, or negligence of myself and others. I voluntarily seek services provided by Rainforest Recovery Center and I acknowledge that I must comply with all set procedures to reduce the spread while in treatment at Rainforest Recovery Center.

I agree to:
-Presenting to Treatment with a negative COVID test within the last 72 hours.
-Quarantine between time of my COVID test and arrival at RRC.
-Contact RRC if I experience COVID symptoms before arrival.
-Weekly COVID testing.
-Wearing a mask when I am not in my room.
-Maintain social distancing with the goal of being 6 feet apart.
-Frequent hand washing.

I hereby release and agree to hold Rainforest Recovery Center harmless from, and waive on behalf of myself, my heirs, and any personal representatives any and all causes of action, claims, demands, damages, costs, expenses and compensation for damage or loss to myself and/or property that may be caused by any act, or failure to act of the unit, or that may otherwise arise in any way in connection with any services received from Rainforest Recovery Center. I understand that this release discharges Rainforest Recovery Center from any liability or claim that I, my heirs, or any personal representatives may have against the unit with respect to any bodily injury, illness, death, medical treatment, or property damage that may arise from, or in connection to, any services received from Rainforest Recovery Center. This liability waiver and release extends to the unit together with all owners, partners, and employees.

Signature: _____ Date: _____

Rainforest Recovery Center
BARTLETT REGIONAL HOSPITAL
3250 Hospital Drive Juneau, AK 99801 907-796-8690 Fax:907-796-8692

Informed Consent for Treatment

** Confidentiality is your right and responsibility**

Confidentiality: Your attendance and all communications between you and your treatment staff, including psychiatrists, are confidential and are not released without your signed consent. Authorization-to-release information forms are available for this purpose. Your RRC records are kept separate from your BRH medical records. The records will be maintained for at least seven years from the last day of service. Rainforest Recovery Center is a part of Bartlett Regional Hospital and as a hospital system we provide integrated care. Only information relevant to specific services will be revealed to the consulting provider/service.

Limits to Confidentiality:

1) When there is a clear and present danger of harm to either yourself or others, we may act on your behalf by arranging hospitalization or notifying others.
2) If you disclose actual or possible current child abuse or neglect, or the abuse, neglect or exploitation of a disabled adult in need of protection, we must report the information to the appropriate department of social services.
3) If we are ordered by a court of law to release information about you, we must do so.
4) In social situations, such as activities off campus, your involvement in Rainforest Recovery Center may be incidentally disclosed.
5) In the event you may need emergency medical care and are brought to BRH you are covered under 42CFR Part 2.
6) Separate Release of Information forms need to be signed for each outside agency you visit while at RRC.

The following Prohibition on Re-disclosure will accompany all information released pursuant to this release: "The confidentiality of the records from which this information has been disclosed is protected under Federal law. Federal regulations (42 CFR, Part 2) prohibits recipients of the information from making any further disclosure without the specific written consent of the person to whom it pertains or other permitted by the regulations. I do not authorize further release to any third party. I understand that once information is released as specified in this authorization, RRC their employees and physician(s) cannot prevent re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information.

I understand that my alcohol and / or drug treatment records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Consumer Records 42 CFR, Part 2 and 45 CFR, and HIPAA and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent through verbal communication or in writing at any time, except to the extent that action has been take in reliance on it. Submit written revocation to the RRC HIM Department.

I have read the above statements. I understand my rights and responsibilities of confidentiality, as well as Rainforest Recovery Center's confidentiality limitations. I agree it is for my benefit during treatment to abide by the appropriate confidentiality agreement listed above to protect my health and safety.

_____ _____

Signature Date/Time

Complete Remaining Pages for Residential Program ONLY:

Facility Rules and Information:

- **We are a tobacco free facility**. Bartlett Regional Hospital (BRH) and Rainforest Recovery Center (RRC) are tobacco free facilities. In accordance with city ordinance, no one is allowed to smoke or use tobacco products while in the Rainforest Recovery Center program. This includes both on and off campus, including community outings and meetings. Nicotine Replacement Therapy is available to you. Smoking items such as cigarettes, e-cigarettes, chew, lighters and matches are considered contraband and will be placed in storage or destroyed.
- **Health**. Prior to entering RRC, you had a complete medical examination and were determined fully able to participate in our program, which includes attending all groups and outings. While in RRC's program your focus of treatment here is on your substance use disorder. If you have experienced a change in health care needs, which require procedures or treatment that would take you away from treatment, it is your responsibility to inform RRC prior to admission. You will have the opportunity to see our attending physician once per week. In the case you become ill while in our program there is accessibility to telephonic consultation with a physician 24/7.
- **Program Modality**. The residential program utilizes evidence-based treatment modalities for substance use and many co-occurring mental health disorders.
- **Participation**: Group and activity attendance are a crucial part of treatment, your participation is mandatory for all groups.
- **Random Drug/Alcohol Screening**. A breathalyzer (BrAC) test and an observed Urine Drug Screen (UDS) will be completed at the time of admission and randomly throughout your stay.
- **Room Searches**. As part of residential drug and alcohol treatment, RRC may at any time conduct a thorough search of individual patients' belongings and living spaces.
- **No Electronics**. For patient safety and confidentiality, patients are not allowed cell phones or electronic devices in treatment. This includes cell phones, iPods, iPads, tablets, computers, mp3 players, cameras, and other electronic recording devices or equipment. Any electronic device arriving with a new patient will be held in storage until discharge.
- **Telephone use**. The phone will be available every day during scheduled times. Telephone calls are NOT allowed during any scheduled activity. In emergencies, the counselor can approve phone calls made with supervision from their offices.
- **Medications.** Any medication prescribed by the RRC psychiatric provider will be supplied for the duration of your stay. You will not be able to take your own medication. Any medication brought to RRC that is not prescribed upon discharge may be disposed of.
- **Living Area**. Please help to keep RRC and your room clean and neat. For housekeeping purposes your linens can be changed once a week. Laundry facilities and products are provided.
- **Elopement Policy.** Under our care, staff will perform checks to ensure your safety. If you are absent from RRC, without informing staff, then you will be considered to have left the residential program against medical advice and will be discharged.

Signature: _____ DATE: _____

- **Property Boundaries**. All patients are provided with a map detailing the property boundaries. While participating in off campus activities, you must stay within eye sight of staff at all times. You are not allowed in the following areas unless with staff:
  - Bartlett Regional Hospital building
  - Wildflower Court and parking lot
  - Withdrawal Management Unit
  - Vehicles in the parking lot
  - Surrounding wooded areas
  - The front reception area

- **Mail.** You can send and receive mail during your stay at RRC. Mail delivered after your discharge will be returned to sender. If you want to receive mail, give your sender the following address:

(Your Name)
c/o Rainforest Recovery Center
3250 Hospital Drive
Juneau, AK 99801

- **Visitors**: Due to COVID, there will be no in person visitation at RRC.

What To Bring

- Enough clothing for seven days. Limit your clothing to one suitcase and a small personal bag such as a purse or backpack. Washer and dryer are available.
- Bring a warm coat, gloves, winter hat and boots for outdoor activities. Waterproof material is preferable.
- Hand lotion, shampoo, conditioner, hairdressing gels, deodorant, etc. These items must not have propylene glycol, ethylene glycol, diethylene glycol, methanol, isopropanol (isopropyl alcohol), and ethanol (ethyl alcohol) listed within the first three ingredients. Other alcohol derivates such as cetyl, stearyl, cetearyl, lanolin, and denatured are ok to bring.
- Hairbrush and/or comb, toothbrush and toothpaste.
- You are expected to dress appropriately. Any clothing which is determined to distract or has the potential to distract will be locked away until discharge. Tight T-shirts, pants, shorts, low-cut tops, excessively loose or revealing clothing, are prohibited and you will be asked to change into more appropriate clothing. Clothing which advertises or glorifies alcohol or drug products is prohibited.
- Baggage is kept in a storage locker and accessed during arrival and departure. Contraband is locked away and may be returned upon discharge.
- No more than $50 will be allowed on your person at RRC and you are given the opportunity to secure it in storage. Any money over $100 will be stored in the safe at the hospital.

Signature: _____ DATE: _____

Do Not Bring

- Alcohol, marijuana, tobacco products, including e-cigarettes, chew, and vapors, and any over-the-counter, prescription, un-prescribed, or illegal drugs.
- Weapons of any sort.
- Pornography or any sexually explicit material (i.e. dildos, vibrators, and/or other sex toys, personal pleasure objects, and paraphernalia).
- Toiletry articles containing propylene glycol, ethylene glycol, diethylene glycol, methanol, isopropanol (isopropyl alcohol), and ethanol (ethyl alcohol) within the first three ingredients, i.e. hair gels, shampoo, conditioner, aftershave, mouthwash, etc.
- Perfumes or other fragrances. BRH/RRC is a fragrance-free facility.
- Personal IPod's, IPad's, tablets, MP3 players, personal dvd players, dvds, or hand-held games. Any electronic devices.
- Any item which is determined to distract, or has the potential to distract from the treatment program will be locked in RRC storage until discharge.
- Cell phones will be kept in storage and may not be utilized during your stay unless for specific approved treatment purposes.

Rainforest Recovery Center Comments and Complaint Procedure

Comments: Rainforest welcomes comments, opinions, and recommendations regarding RRC services. You are asked to tell us about your experience at RRC. You will be asked to fill out a patient satisfaction survey. You will also be given a survey at the time of discharge from the State of Alaska.

Grievance: If you have a complaint concerning the program, staff, or facility, you may seek resolution in several ways. If you are participating in the residential or outpatient program, please contact your primary counselor for assistance.

If you have immediate concerns, you are encouraged to communicate with any of the following:

1. Communicate with the person directly
2. Your primary counselor or available RRC staff member
3. The RRC Program Director, Medical Director, or Chief Behavioral Health Officer
4. The Bartlett Regional Hospital Quality/Risk Manager (907) 796-8695

A grievance is a formal or informal, written or verbal communication that is made to the hospital by a customer, regarding dissatisfaction with the care that was received during a hospital visit. Grievances will be communicated to the Quality Director or Risk Manager and a response is made within 7 days.

Signature: _____ **DATE:** _____

BARTLETT REGIONAL HOSPITAL
RAINFOREST RECOVERY CENTER
PATIENT RIGHTS AND RESPONSIBILITIES

PATIENT RIGHTS: As a patient at Bartlett Regional Hospital (BRH) and Rainforest Recovery Center (RRC) you have the right to:

ACCESS TO CARE:

- To impartial access to care, treatment and services that are available and clinically indicated regardless of race, creed, sex, national origin, education, economic status or source of payment for care
- To be informed of your rights and responsibilities at the time of admission as well as circumstances in which those rights may be suspended or violated.

CONSENT FOR TREATMENT

- To consent to treatment prior to receiving the treatment and be informed of risks of serious side effects and the possibility of success of the treatment.
- The consent to treatment is given voluntarily and explained to you in a method you understand.
- To refuse to participate in research or to be filmed or photographed or fingerprinted for external purposes. Specific consent will be obtained prior to you participating in these activities.
- To refuse treatment to the extent permitted by law and to know that such refusal will not affect the care delivered. When in the view of the provider, refusal of treatment by you or your legally authorized representative prevents the provision of appropriate care in accordance with professional standards, the relationship between you and the provider may be terminated upon reasonable notice and finding alternative care.

PERSONAL RIGHTS

- To wear your own clothing, to keep personal possessions (unless they may be used to endanger your own or another's life) and to keep and spend a reasonable sum of your own money.
- To have access to an individual space for storage for your private use
- To have reasonable access to phones, both to make and receive confidential calls.
- To have any restriction of visitors, mail, telephone calls or other forms of communication explained to you at the time of admission according to program rules.
- To send and receive unopened correspondence (not packages). Personal belongings may be subject to search for the purpose of securing contraband.
- To reasonable access to an interpreter if you do not speak English or are hearing impaired.
- To formulate advanced directives regarding healthcare decisions and to have staff comply with these directives consistent with applicable laws and professional medical standards.

RIGHTS CONCERNING CARE, TREATMENT AND SERVICES

- To medical, psychosocial and rehabilitative care including prompt and appropriate medical treatment and care.
- To be free of abuse, neglect, and aversive interventions
- To be given complete explanation of the need for transfer to a different facility or different level of treatment prior to the transfer occurring.

Signature: _____ DATE: _____

- To request and receive an itemized and detailed explanation of the total bill for services rendered.
- To know the name and professional status of individuals providing direct patient care and the individual primarily responsible for your care.
- To receive treatment in a safe and secure environment which is appropriate for your needs.
- To pastoral or other spiritual services, in accordance with RRC program scheduling.

INDIVIDUAL PLAN OF SERVICES

- To an individual plan of services developed with you and your primary therapist and updated as changes occur.
- To treatment in the least restrictive environment that may reasonably be expected to benefit you.
- To appoint a surrogate decision maker when you are unable to make decision about care, treatment and services and to have family, as appropriate, involved in decisions about care.

RIGHT TO INFORMATION

- To inspect your records upon reasonable request and in accordance with RRC and BRH policies regarding access to records.
- To obtain information in a method you can understand.
- To have all information and records obtained in the course of evaluation, examination, and/or treatment kept confidential (42 C.F.R. Part 2 and HIPAA) and not made public except as may be required by an appropriate court order. RRC staff are mandatory reporters of children or vulnerable adults at risk of abuse or neglect. We are permitted to contact individual(s) or law enforcement agencies if you have made a specific threat of harm to someone else and we determine there to be a clear and immediate probability of you acting on that threat.

CONFLICT RESOLUTION

- To be informed of the process to assist you and your family in resolving conflicts regarding care decisions.

DENIAL OF RIGHTS

- To have your rights denied only when necessary to protect your health and safety or to protect the health and safety of others.

PATIENT RESPONSIBILITIES - These responsibilities are presented to the patient in the spirit of mutual trust and respect. Your responsibilities are as follows:

- To provide accurate and complete information concerning present complaints, past illnesses, hospitalizations, medications and other matters relating to his/her health.
- To report perceived risks in your care and unexpected changes in your condition to your responsible practitioner.
- To ask questions when you do not understand what you have been told about your care or what you are expected to do.
- To follow the treatment plan established by you and your treatment team. If you choose not to follow the plan, you are responsible for your actions.
- To keep appointments and attend treatment activities as assigned and notifying staff when you are unable to do so.
- To assure that the financial obligations of hospital care are fulfilled as promptly as possible and to realize that you ultimately are responsible for all charges.
- To follow hospital and RRC policies and procedures.
- To be careful with personal property and that of other persons in the facility. Respect the rights of others.

Signature: _____ DATE: _____

Rainforest Recovery Center
BARTLETT REGIONAL HOSPITAL
3250 Hospital Drive Juneau, AK 99801 907-796-8690 Fax:907-796-8692

AUTHORIZATION FOR RELEASE OF INFORMATION

Rainforest Recovery Center is a part of Bartlett Regional Hospital and as a hospital system we provide integrated care. By signing this Release of Information you are allowing for consultation with hospital physicians and other hospital staff to allow you to receive the best medical care possible. We ask this release be completed prior to treatment admission so there is no delay in services.

PATIENT INFORMATION

Patient Name: _____ Birth Date: _____ Medical Record # (if known)_____

Address: _____ City / State/ Zip: _____

I Hereby Authorize Rainforest Recovery Center to Release Information TO:

Name of Facility/ Organization / Individual: Bartlett Regional Hospital

Address: 3260 Hospital Drive

City / State / Zip: Juneau, AK 99801 Phone Number: 907-796-8900

I Hereby Authorize Rainforest Recovery Center to REQUEST Information FROM:

Name of Facility/ Organization / Individual: Bartlett Regional Hospital

Address: 3260 Hospital Drive

City / State / Zip: Juneau, AK 99801 Phone Number: 907-796-8900

☒Purpose or need for information being requested: Further Treatment.
☒Type of Information to be used or disclosed: ☒Entire Record.

I authorize the release of information relating to: Substance Use Disorder Information and Psychiatric Evaluation / Treatment.

This information may be transmitted via Fax, Verbal, Electronically, and Hard Copy.

This Authorization expires 7 years from signing to enable ongoing coordination of care.

I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment at RRC.I consider a photocopy of this authorization to be as valid as the original. I understand that I may upon request inspect the information to be disclosed.

The following Prohibition on Re-disclosure will accompany all information released pursuant to this release: "The confidentiality of the records from which this information has been disclosed is protected under Federal law. Federal regulations (42 CFR, Part 2) prohibits recipients of the information from making any further disclosure without the specific written consent of the person to whom it pertains or other permitted by the regulations. I do not authorize further release to any third party. I understand that once information is released as specified in this authorization, RRC their employees and physician(s) cannot prevent re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information.

I understand that my alcohol and / or drug treatment records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Consumer Records 42 CFR, Part 2 and 45 CFR, and HIPAA and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent through verbal communication or in writing at any time, except to the extent that action has been take in reliance on it. Submit written revocation to the RRC HIM Department.

I further acknowledge that the information to be released has been explained to me and certify that this consent is being given of my own free will.

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

_____ _____ _____

Signature of Patient or Legally Responsible Party Relationship to Patient Date

Rainforest Recovery Center
3250 Hospital Drive, Juneau, Alaska 99801
Telephone (907) 796-8690 Fax (907) 796-8692

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT INFORMATION

Patient Name:_____ Birth Date:_____ Medical Record # (if known)_____

Address: _____ City / State/ Zip: _____ Box 1

I Hereby Authorize Rainforest Recovery Center to Release Information TO:

Name of Facility/ Organization / Individual: _____

Address: _____

City / State / Zip: _____ Phone Number: _____ FAX: _____ Box 2

I Hereby Authorize Rainforest Recovery Center to REQUEST Information FROM: (*Must be the same person/ organization as box 2)

Name of Facility/ Organization / Individual: _____

Address: _____

City / State / Zip: _____ Phone Number: _____ FAX: _____ Box 3

- ❑ Dates of treatment: From_____ To_____
- ❑ Purpose or need for information being requested:
  Further Treatment _____ Legal Proceedings _____ Insurance Claim _____ Other (specify): _____
- ❑ Type of Information to be used or disclosed

*Must initial on these lines, DO NOT check off

_____Consultation _____History & Physical _____Lab Reports _____ ER Report
_____Discharge Summary _____Progress Notes _____Medication List _____Other: _____

I authorize the release of information relating to:
_____ Substance Use Disorder Information _____ Psychiatric Evaluation / Treatment

Box 4

This information may be transmitted via (patient initial each approved means) ___Fax ____ Verbal ____ Electronically ___Hard Copy

This Authorization expire on the following date, event or condition: _____
If I fail to specify an expiration date, event or condition, this authorization will expire 90 days from the date of signing.

I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment at RRC.I consider a photocopy of this authorization to be as valid as the original. I understand that I may upon request inspect the information to be disclosed.

The following Prohibition on Re-disclosure will accompany all information released pursuant to this release: "The confidentiality of the records from which this information has been disclosed is protected under Federal law. Federal regulations (42 CFR, Part 2) prohibits recipients of the information from making any further disclosure without the specific written consent of the person to whom it pertains or other permitted by the regulations. I do not authorize further release to any third party. I understand that once information is released as specified in this authorization, RRC their employees and physician(s) cannot prevent re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information.

I understand that my alcohol and / or drug treatment records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Consumer Records 42 CFR, Part 2 and 45 CFR, and HIPAA and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent through verbal communication or in writing at any time, except to the extent that action has been take in reliance on it. Submit written revocation to the RRC HIM Department.

I further acknowledge that the information to be released has been explained to me and certify that this consent is being given of my own free will. Box 5

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

_____ _ _____ _____
Signature of Patient or Legally Responsible Party Relationship to Patient Date

_____ (Witness) Date_____

Box 6