



Consent for Evaluation, Assessment, Treatment And Release of Referral Information

Before we begin working with you we are required to have your consent for evaluation, assessment and, if appropriate, treatment. Please read the following statement:

I, , certify that I am making application for evaluation, assessment, if appropriate, treatment with Phoenix House. I give consent for the staff of Phoenix House to begin the initial evaluation, assessment and/or treatment. I also hereby consent to the release of my evaluation, assessment, treatment and referral information by Phoenix House to the source(s) of my referral as indicated below. The individuals to whom the disclosure is to be made are **(please check each box that applies and add the name of the individual who serves in that role):**

☐ Judge , of the Court, or their successor or designee.

☐ , the prosecuting attorney, or their successor or designee.

☐ , my attorney, or their successor or designee.

☐ , my probation officer, or their successor or designee.

☐ , my parole officer, or their successor or designee.

☐ , my drug court agency liaison, or their successor or designee.

☐ , my child protective services agency case worker, or their successor or designee.

☐ , my/the , or their successor or designee.

(Add the name and title/role of any other individual who needs to receive information from Phoenix House in connection with your participating in the drug court program or in connection with your criminal case, probation or parole).

I understand that my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abused Patient Records, 42 CFR Part 2, 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 with one calendar year from the date indicated by my signature below.

I understand that this consent will remain in effect until there has been a formal termination or revocation of the conditions of my sentence, probation or parole by the court and/or agency under which I have been mandated to Phoenix House for treatment. If I choose to revoke this consent prior to the formal termination or revocation of these conditions, then Phoenix House, under the terms of its reporting requirements to the court and/or agency, will inform the appropriate individuals of my decision to withdraw my consent. I may revoke this consent, in whole or with respect to one or more of the individuals named above, in writing at any time except to the extent that action has already been taken in reliance upon it, and, in any event, this consent will automatically expire when there has been a final disposition of the conditional release, or other action under which this consent was given, by the court and/or agency.

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.

Signature of Patient	Date	Signature of Person Signing Form if Not Patient	Date
<div style="border-top: 1px dashed black; height: 15px; margin-bottom: 5px;"></div> Describe Authority to Sign on Behalf of Patient			

Prohibition on Re-disclosure: Drug and alcohol treatment information is disclosed from records whose confidentiality is protected by federal regulations governing *Confidentiality of Alcohol and Drug Abuse Patient Records*, 442 U.S.C. Federal rule 42 CFR part2 prohibits re-disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations.



Consent to Obtain and/or Release PHI

I, , authorize Phoenix House to obtain from and/or release to the following parties my protected health information (PHI) identified below for the purpose of communicating with such parties regarding, and informing such parties of, my attendance, progress and treatment at and discharge from Phoenix House. I understand that such disclosure of my PHI by Phoenix House may include, among other things, having Phoenix House employees or representatives testify at a court or agency hearing or in open court.

The individuals to whom the disclosure is to be made are **(please check each box that applies and add the name of the individual who serves in that role):**

☐ Judge , of the Court, or his/her successor or designee.

☐ , the prosecuting attorney, or his/her successor or designee.

☐ , my attorney, or his/her successor or designee.

☐ , my probation officer, or his/her successor or designee.

☐ , my parole officer, or his/her successor or designee.

☐ , my drug court agency liaison, or his/her successor or designee.

☐ , my child protective services agency case worker, or his/her successor or designee.

☐ , my/the , or his/her successor or designee.

(Add the name and title/role of any other individual who needs to receive information from Phoenix House in connection with your participating in the drug court program or in connection with your criminal case, probation or parole)

Purpose of disclosure: Consideration for admission to the Phoenix House residential substance abuse treatment program located in Citra, Florida.



Check the appropriate boxes to specify the type of PHI that may be obtained and/or released:

- ☐ Status/Location of patient's treatment (e.g. active, program completed)
- ☐ Admission/Induction Records
- ☐ Progress Information
- ☐ Attendance Information
- ☐ Discharge or Termination Information
- ☐ Drug Test Results
- ☐ All Alcohol /Drug Treatment Records
- ☐ All Medical records (other than HIV records) Patient must sign a separate form to release HIV records.
- ☐ All Psychiatric/Psychological/Psychosocial Records
- ☐ All Vocational Records
- ☐ Records received by Phoenix House from third-party agencies, organizations, courts, substance use treatment providers or health care providers
- ☐ Specified Medical Records:
- ☐ Other Records/Information (specify):

I understand that my 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, 45 C.F.R. pts 160 & 164, and therefore cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I understand that this consent will remain in effect until there has been a formal termination or revocation of the conditions of my sentence, probation or parole by the court and/or agency under which I have been mandated to Phoenix House for treatment. If I choose to revoke this consent prior to the formal termination or revocation of these conditions, then Phoenix House, under the terms of its reporting requirements to the court and/or agency, will inform the appropriate individuals of my decision to withdraw my consent. I may revoke this consent, in whole or with respect to one or more of the individuals named above, in writing at any time except to the extent that action has already been taken in reliance upon it, and, in any event, this consent will automatically expire when there has been a final disposition of the conditional release, or other action under which this consent was given, by the court and/or agency.



Signature of Patient

Date

Signature of Person Signing
Form if Not Patient

Date

Describe Authority to Sign on Behalf
of Patient

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