ALIVIANE INC.

Behavioral Health Solutions Since 1970

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FAX

To: Patricia Bailey	From: Laura Faudoa
Fax: 512-206-5211	Pages: 3 with cover
Phone:	Date: 5-26-09
RE:	CC:

☐ Urgent	☐ For Review	☐ Per Your Request	☐ Please Comment	☐ Please Reply

Comments: Pat this is what we use at Aliviane, El Paso Texas, for consent and release of information

Thank You
Laura

Email:

Alivian~ Inc.

CONSENT TO TREATMENT

Date:_____ Name:_____

CONSENT FOR TREATMENT INVOLVING MINOR:

If this consent is for treatment of a minor under Section 35.01, Texas Family Code, the following information must be provided:

1) Name of one or both parents, if known:_____

2) Name of legally authorized representative of person, if appointed:_____

3) Date on which treatment is to begin:_____

Based upon this explanation, I hereby consent to treatment at _____ *(Name of facility)*. I understand that I may withdraw this consent at any time, except to the extent that action has already been made in reliance upon it. I understand that this consent will expire upon my discharge from Aliviane Inc. treatment and aftercare.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian/Conservator Signature Date

_____ _____
Staff Signature Date

Reason individual is unwilling/unable to sign:_____

_____

_____

_____

_____

Revised 4/27/2006

Aliviane, Inc.

Authorization to Release Confidential Information

Client Name:_____ Date:_____

DOB:_____ SS No:_____

I,_____, authorize

Client or Client's legally responsible person or personal representative

_____

Agency or Person Authorized to Use or Disclose the Information

to disclose to_____

Agency or Personal to Whom the Requested Use or Disclosure will be Made

the following protected information:_____

Provide a specific and meaningful description of the information to be used and disclosed

_____

_____

_____

The **Purpose of the Disclosure** is_____

Describe each purpose of the requested use or disclosure

_____

_____

Redisclosure

Once information is disclosed pursuant to this signed authorization, I understand that the federal health privacy law (45 C.F.R, Part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. When Aliviane, Inc., discloses Substance Abuse Treatment Information protected by federal law (42 C.F.R, Part 2), we must inform the recipient of the information that redisclosure is prohibited except as permitted or required by this law. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Revocation and Expiration

I understand that I have the right to revoke this authorization at any time except to the extent that the program is to make the disclosure has already taken action in reliance on it. If I want to revoke this authorization, I must do so in writing. If not revoked earlier, this authorization expires automatically upon:

Date of Expiration:_____

Specific date, event or condition that authorization expires

Notice of Voluntary Signature: I understand that I may refuse to sign this form. If I choose not to sign this form, I understand that Aliviane, Inc., cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits based on my refusal to sign.

Signature of Client:_____ Date:_____

Signature of Staff:_____ Date:_____

Signature of legally responsible person or other personal representative (if applicable, please provide explanation as to authority to act on behalf of client):

_____ Date:_____

_____ I have received a copy of this authorization.

Client Initials

This form implements the requirements for client authorization to use and disclose health information protected by the federal health privacy law (45 C.F.R., Parts 160, 164) and federal drug and alcohol confidentiality law (42 C.F.R., Part 2) as well as HIPAA requirements.