

**RESIDENCE XII
EXCHANGE OF INFORMATION**

For The Recipient of the information:

*This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is **NOT sufficient** for the purpose. The Federal Rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug patient.*

I _____ requests that Residence XII and _____
(Patient Name) (Contact Person)
Phone Number: _____ Fax: _____
Address _____

exchange information and/or exchange copies of specified records as directed below.
(Patients please place initials next to brackets indicating your choices.)

Records The following records and/or information included in this request:

- Treatment summary: including identity, dates, diagnosis, prognosis, recommendations, treatment rendered, location, progress, and treatment status.
- Social history.
- Medical history.
- Family and significant other information.
- Results of physical examination.
- Lab tests including U/A results.
- All records and documents in file.
- Knowledge of presence in treatment or in the treatment facility.
- Other _____

Purpose. The purpose of this request is:

- Status report/progress report
- Continuity of care
- Insurance reimbursement/managed care monitoring
- To provide program information
- To contact in case of emergency
- Other _____

Duration & Revocation. I understand that my chemical dependency treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient records, 42 CFR, Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 CFR, Parts 160 and 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

Residence XII Consent

in writing at any time except to the extent that action has been taken in reliance on it, and that in any event unless earlier, this consent will expire in: 90 days from the last date signed below.

I understand that generally Residence XII 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.

4. Delivery Instructions:

Mail: FAX to: _____
 Phone: Other: _____

Residence XII Mailing Address: 12029 113th Ave NE, Kirkland, WA, 98034.

Fees. Residence XII may charge a reasonable fee for copying and providing such copies.

Patient Name - Print _____

Patient - Signature Date

Witness - Signature Date

Patient - Signature Date

Witness - Signature Date

Patient - Signature Date

Witness - Signature Date