

**Consent for the Release of Confidential Information  
Probation/Insurance**

I, \_\_\_\_\_ authorize Sees-The-Day, Inc. to disclose to \_\_\_\_\_  
*Resident Name* *Agency Name*

the following information:

- 1) Whether or not the resident is in treatment.
- 2) Prognosis of the resident.
- 3) The nature of the project.
- 4) A brief discussion of progress of the resident
- 5) A short statement as to whether or not there has been a relapse into drug or alcohol abuse, and the frequency of such a relapse.

This information can be released for the purpose of:

- \_\_\_\_\_ Determination of treatment needs
- \_\_\_\_\_ Continuity of care
- \_\_\_\_\_ Coordination of services
- \_\_\_\_\_ Compliance with probation/parole regulations
- \_\_\_\_\_ Obtaining assessment/evaluation information
- \_\_\_\_\_ Other: \_\_\_\_\_

For those on Probation or Parole, the Pennsylvania Department of Health, ODAP Policy as of October 1992 mandates the above-restricted release of information.

I understand that my records are protected under the Federal Confidentiality regulations and cannot be disclosed without my express 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, e.g. probation/parole, etc. In addition, that in any even this consent automatically expires in three (3) months following discharge from treatment.

Specification of the date, event or condition upon which this consent expires: \_\_\_\_\_

\_\_\_\_\_  
*Residents Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Witness Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_ I have been offered and received a copy of this consent.

\_\_\_\_\_ I have declined the offer of a copy of this consent.

\_\_\_\_\_  
*Residents Signature*