Changes Counseling & Consultation, LLC

We Care

8221 S. 700 E. Sandy, UT 84070
Phone: (801) 542-7060 Fax: (801) 542-7061
info@changescounseling.org www.changescounseling.org

CONSENT FOR THE TWO-WAY RELEASE OF CONFIDENTIAL INFORMATION

Client Name:

Please Note: If your treatment is subject to supervision by a court, probation officer, or other supervising agency, you are required to provide proof of ongoing compliance to that agency. **Unless you specify otherwise below**, signing this document authorizes communication regarding your compliance between Changes Counseling, LLC. and your reporting agency (if any). As needed, this may include the sharing of HIPAA-protected information with your Medicaid Administrative Network, such as: Molina, Optum and its subsidiaries, Healthy U of U, Health Choice Steward, Select Health, Medicaid Fee-for-Service, or TAM.

☐ *(Check this only if you're sure): I **do not** authorize communication with my court, probation officer, or reporting agency (if any).*

☐ *(Check this only if you're sure):* I want my evaluation sent **only** to my attorney, or other (please specify:).

(PLEASE LIST EVERYONE WHO NEEDS TO KNOW YOU CAME! *(List fax/email if possible)*

Court:	**Fax/Email:**	**Phone:**
➢ Case Number(s), if applicable:		
P.O./Agency:	**Fax/Email:**	**Phone:**
Attorney:	**Fax/Email:**	**Phone:**
Spouse/Family:	**Fax/Email:**	**Phone:**
Other:	**Fax/Email:**	**Phone:**

The information I authorize to be disclosed is (check applicable items):

☒ Evaluation results, treatment recommendation, treatment summaries, progress reports, notice of completion/non-compliance;

☒ **MEDICAID CLIENTS:** I acknowledge and consent to the sharing of relevant information between Changes Counseling and my Medicaid network, including: evaluations, progress notes, Outcome Questionnaire (OQ-30/OQ45.2) results, etc.

OR: ☐ OTHER/I ***do not*** consent for certain information to be shared with the Medicaid Administrative Network Provider: *(Please Specify):*

I understand that my treatment records are protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts 160 & 164, and any alcohol and/or drug treatment records are protected under the federal regulations governing of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2. I understand that my treatment records cannot be disclosed without my written consent unless otherwise provided for in the regulations; and that I may revoke this consent with **written** notice.

IF YOU WANT TO LIMIT DURATION OF THIS ROI, PLEASE SPECIFY EXPIRATION CONDITIONS BELOW:

❑ Six months following the discharge date from **Changes Counseling & Consultation, LLC.,**	***O R***	❑ Six months following a formal and effective release from confinement, probation, parole or other proceeding under which I was mandated to attend treatment.	***OR***	❑ The th day of Year

I have read the above, understand it and hereby give my consent to the above-mentioned disclosure.

Client E-Signature Guardian Name/E-Signature (if under 18) Date