**Western Psychological and Counseling Services**
**Consent to Disclose Substance Use Disorder Patient Records**
**Criminal Justice System**

**Client Name:** (please print): _____
**Other names used in treatment, if any:** _____

**I authorize Western Psychological to exchange information regarding my treatment and participation in Western Psychological and Counseling Services, Inc's Substance Use Disorder Program:**

**Name:** ___**DMV**_____ **Attention:** __**Driver Suspension Unit**___

**Address:** **1905 Lana Ave. NE**_____ **Phone:** ___**503-945-5086**_____

**City-State, Zip:** __**Salem, Oregon 97314**_____ **Fax:** _____**503-945-5096**_____

**Initial all types of A/D information to be disclosed to above party/from the above party:**
Treatment related:
____ (**Initial**) To verify treatment dates/discharge status
____ (**Initial**) SUD evaluation and recommendations
____ (**Initial**) Attendance
____ (**Initial**) Legal information
____ (**Initial**) DMV/DOL information
____ (**Initial**) Other: (**specify**)_____

**Purpose for the disclosure of the above information authorized herein is to: (Initial and write specific reason)**

____ (**Initial**)(**Coordination of care)**

**This consent will terminate upon: (specific date, event, or condition):**

**Event expiration:** _____**90 days after completion of course of treatment and/or payment in full for services**
**(Initial) provided**

**I understand that:**

I understand that I do not need to sign this consent. If I refuse to sign this, it will not prevent me from getting drug/alcohol treatment at Western. The only exception is if the services I am seeking are only for providing health information to someone else and this consent is needed to make the disclosure.

I understand that the information used or disclosed as a result of this consent may be subject to re-disclosure and no longer protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of drug/alcohol diagnosis, treatment, or referral information.

**I have read and understand this consent:**

**Client Signature:** _____ **Date:**_____

**If personal representative, print name:** _____

**Relationship to client: ( Please initial)**
____ **(Initial) Parent**
____ **(Initial) Legal Guardian**
____ **(Initial) Power of Attorney/healthcare**

**Personal Representative Signature:** _____ **Date:** _____

**Witness:**_____ **Date:** _____

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.