CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, ________________________________, DOB ___________________________, authorize PPS Counseling Services to disclose to:

- (initial) _________ The **Missouri Department of Mental Health** and
- (initial) _________ The **Missouri Department of Revenue**, the following information:
- The results of my SATOP screening, program participation, and completion and discharge information.
- Additionally, I authorize the Missouri Department of Mental Health to disclose to the Agency the following information for each of its contracted substance use treatment service providers: Assessment, Continuing Care Plan, Diagnosis, Progress in Treatment, Treatment Plan or Summary, Discharge/Transfer Summary, Presence/Participation in Treatment, Other ______________________________

I also authorize disclosure to:

____
Name

Purpose
The purpose of the above disclosure is to provide the Agency with the necessary treatment information to make a determination regarding appropriate SATOP placement and the reinstatement of driving privileges.

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to PPS Counseling at 902 Edmond St. Joseph, MO 64501. I further understand that a revocation of the new authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration
Unless sooner revoked, this authorization expires one year from the date of signature below.

Conditions
I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulation. However, I further understand that failure to sign this Consent for Release of Confidential Information may have the following consequences: Non-completion of the Substance Abuse Traffic Offender Program (SATOP)

Form of Disclosure
Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format, or electronically.

I will be given a copy of this authorization for my records upon request. My signature below acknowledges that a copy of the Notice of Private Practices from PPS Counseling has been made available to me.

____ _____________________
Signature of Consumer Date

____ _____________________
Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney), healthcare surrogate, etc.).

_________ Check here if patient/client refuses to sign authorization

____ _____________________
Signature of Staff Witness Date