

**INOVA COMPREHENSIVE ADDICTION TREATMENT SERVICES**  
**3300 GALLOWS ROAD**  
**FALLS CHURCH, VA 22042**  
**(703) 776-7777**  
**(703) 776-7799 FAX**

I, \_\_\_\_\_ authorize INOVA COMPREHENSIVE ADDICTION TREATMENT SERVICES TO OBTAIN FROM AND/OR DISCLOSE TO:

Name of individual and/or organization	Relationship
Street Address	Phone number
City	State
Zip code	Fax number

The following information/records:

Yes	No	Information to be disclosed
		Admission to the program
		Assessment and Diagnosis (Axis 1-5)
		Treatment plan goals and objectives
		Progress towards accomplishing treatment plan goals and objectives
		Results of drug screens and breathalyzer tests
		Compliance with treatment recommendations and referrals
		Program participation
		Diagnostic Lab Work
		Financial Documentation
		Other:

For the purpose of:

	Service coordination
	Participation in family program
	Completion of family interview
	Reports to Probation Office or Attorney
	Other:

I understand that my records are protected under Federal and State Confidentiality laws and cannot be disclosed without my written consent unless otherwise provided for in the law and 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. I understand written notification is necessary to cancel this authorization and can be addressed to the department listed at the top of this form. I understand that in any event this consent automatically expires 90 days after the end of the continuum of treatment at Inova CATS. I understand that if the person or agency that receives my information is not a health plan covered by the HIPAA privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

I further acknowledge that the information to be released was fully explained and that this consent was given of my own free will and understand Inova Comprehensive Addiction Treatment Services may not condition treatment on my decision to sign this authorization.

This consent includes information placed in my records after the date of the signature below.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Note, where information accompanies this disclosure form. 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 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.

**Addressograph**

**INOVA COMPREHENSIVE ADDICTION TREATMENT SERVICES**  
**Authorization to Release Protected Health Information**  
**MR-10-56(REV 05/09)**