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## Consent for Release of Confidential Information

I, , whose Date of Birth is , authorize Eastern Missouri Alternative Sentencing Services, Inc. to disclose to: The Missouri Department of Mental Health and the Missouri Department of Revenue, the following information:

##### The results of my SATOP screening, program participation, and completion 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:

*(Patient/Client should initial each item to be disclosed)*

 Assessment

Diagnosis

Treatment Plan or Summary

Presence/Participation in Treatment

Discharge/Transfer Summary

Continuing Care Plan

Progress in Treatment

Other 

Other 

#### 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 Stephanie Roper at #8 Westbury Dr, St. Charles, MO 63301. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires on the following date: One year from signing or as otherwise indicated: 

##### 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.

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  Signature of Client 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 client refuses to sign authorization

Signature of Staff Witness Date