Contact Counseling

Bob Chambers MA CDP
Director

1118 Finnegan Way, Ste 103
Bellingham, WA 98225

Phone: (360) 671-3277
Fax: (360) 733-9499

Instructions for Allowing Contact Counseling to Speak with Friends and Family

Contact Counseling assumes that by sending a completed release of information to us, you are giving us permission to speak with the person indicated on the release of information.

If you would like Contact Counseling to be able to speak to a friend, family member, or spouse in regards to the coordination of your appointment, we will need you to print and complete the release of information (page 2 of this document) authorizing an exchange of information and return it to Contact Counseling.

On the release of information be sure to include the following:

- Your full name and date of birth
- The name of the person you wish to relevant contact information
- Your initials where indicated
- Your signature and the date signed
- The signature of a witness (this can be anybody over the age of 18, except for the person(s) to whom you are releasing information)
- Your phone number and approximant date of your assessment.

Please note that if the release of information is in any way incomplete, we will be unable to confirm or deny details pertaining to your appointment with the individual listed on the release.

Once complete please return the release by email to contactc4u@gmail.com, by fax to (360) 733-9499,

Or, simply mail the release to:

Contact Counseling
1118 Finnegan Way, Ste 103
Bellingham, WA 98225

Please do not hesitate to be in touch with any questions at (360) 671-3277, we are happy to help.

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DISCLOSURE AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____ DOB: _____, hereby authorize an exchange of
(Full Name of Participant)

information between Contact Counseling and _____.
(Name of person/agency obtaining/receiving information, & relevant contact information)

Please **initial** the substance abuse information to be obtained, release and/or exchanged:

_____ Assessment (Allows the person/agency listed above to receive details of your assessment, in writing or verbally, at the discretion of Contact Counseling. This may include details of the conversation, results of testing, and treatment recommendations)

_____ Collaborative Information (Allows the person/agency listed above to provide additional information to Contact Counseling for your assessment)

_____ Scheduling Assistance (Allows the person/agency listed above to assist you with scheduling, payment, and translation as needed)

_____ Other (specify): _____.

Please **initial** the purpose or need for the exchange and disclosure of this information:

_____ Facilitate Treatment _____ Summarize Recommendation _____ Consultation

_____ Other (specify): Coordinate appointment.

I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I also understand that I may revoke this authorization at any time, except to the extent that action has been taken in reliance on it. Unless revoked earlier, I understand, that from the date of signing, this release shall expire as specified below:

6 months.

I understand my treatment may not be conditioned on whether I sign a consent form, but in certain limited circumstances I may be denied treatment if I do not sign a consent form.

_____ _____
Patient Signature Date

_____ _____
Parent or Guardian (for minors) Date

_____ _____
Witness Date

In case we need to get in touch, please provide:

Participant Phone: _____

Date or Year of Assessment: _____