Women's Recovery Center
treating addiction, liberating lives

6209 Storer Avenue
Cleveland, OH 44102-5522
Tel: 216.651.1450
Fax: 216.651.1450

www.womensctr.org

Let us help **you** to make a referral for an alcohol and other drug assessment and intensive outpatient treatment services. The treatment is individualized with trauma integrated services. The benefits include:

> Scheduled within 5–7 days
> Offering morning and evening treatment hours for women
> All women over the age of 18 are eligible for treatment
> Parenting classes
> Individual and Family Counseling
> Art Therapy
> Case management and referral services
> Public transportation vouchers
> Submission of reports and results!

How to start the process?

> Fax a signed Release of Information or fax the Substance Abuse Assessment if it is less one year old
> Provide the contact information to the potential client
> A Clinical Staff Member will conduct a 15 minute telephone or face-to-face screening
> The Clinical Staff Member will keep you informed of the Intake Date, attendance, urinalysis screening results and other information that may be required.

Referring Agency_____ Contact_____

Telephone Number_____ Email Address _____

Mailing Address _____

Client Name_____ Telephone Number _____

WOMEN'S RECOVERY CENTER AUTHORIZATION TO DISCLOSE INFORMATION

Name of Client: _____ Date of Birth: _____

Women's Recovery Center is authorized to: ☐ disclose ☐ receive ☐ exchange information as noted below to:

_____
Authorized Individual/Organization to Whom Disclosure is Made

Purpose of Disclosure: ☐ to coordinate treatment ☐ to gather assessment information for treatment planning
☐ to gather information for ongoing treatment ☐ other purposes (specify) _____

Type of Information to be Disclosed:

☐ progress notes
☐ diagnostic assessment of information
☐ progress in treatment
☐ lab results
☐ urine testing
☐ attendance
☐ HIV/AIDS testing or status
☐ pregnancy testing
☐ prenatal care
☐ diagnosis
☐ information on mental illness and/or treatment
☐ discharge summary
☐ other information (specify) _____

Amount of Information to be Disclosed: ☐ information covering the previous three months ☐ information covering the most recent admission
☐ other amount of information (specify) _____

_____
Signature and Date of Client or Other Person Authorized to Permit Disclosure

_____
Signature and Date of Staff or Witness

Revocation: This authorization is subject to revocation at any time except to the extent the program or person who is to make the disclosure has already acted in reliance on it. Drug and/or alcohol clients may revoke consent in writing.

I hereby revoke consent in writing: _____
Client's signature and date

Authorization was revoked in writing: Date_____ Time _____

_____
Signature and Date of Person Witnessing Written Revocation

This authorization automatically expires in 365 days unless otherwise noted here: _____

Prohibition Against Re-Disclosure: This information has been disclosed to you from records protected by Federal confidentiality rules. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by 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 information to criminally investigate or prosecute any alcohol or drug abuse client.