AUTHORIZATION FOR DISCLOSURE OF CONSUMER MEDICAL/HEALTH INFORMATION

I, ______________________________, authorize Midwest ADP, Inc. or any of its employees, agents and representatives to disclose information regarding my completion, level of performance and cooperation, any assessment recommendations, and/or SATOP screenings.

To disclose to:

Initial Box

[ ] Missouri Department of Revenue

[ ] Missouri Division of Alcohol and Drug Abuse (SATOP)

[ ] ______________________________
Name of Court or Probation Officer

[ ] ______________________________
Other Individuals or Agencies

[ ] ______________________________
Other Individuals or Agencies

The purpose of the disclosure authorized herein is to: To Facilitate Treatment

I UNDERSTAND THAT MY RECORDS ARE PROTECTED UNDER FEDERAL REGULATIONS GOVERNING CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS, 42 CFR PART 2 AND CANNOT BE DISCLOSED WITHOUT MY WRITTEN CONSENT AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE ON IT, AND THAT IN ANY EVENT THIS CONSENT EXPIRES AUTOMATICALLY ON THE FOLLOWING DATE, EVENT, OR SPECIAL CONDITION: ______________________________
DATE (If date is left blank, consent will expire one year from date release is signed)

My signature below acknowledges that I have received from Midwest ADP, Inc. a copy of the Notice of Privacy Practices.

Signature of Consumer: ______________________________ Date: ______________

Signature of Parent/Legal Guardian/Representative: ______________________________ Date: ______________

Signature of Witness: ______________________________ Date: ______________

NOTICE OF REVOCATION

I, ______________________, (Consumer) hereby revoke my authorization of this disclosure of information to the agency/person listed above. This revocation effectively makes null and void any permission for disclosure of information expressly given by the above authorization. I understand that any actions based on this authorization, prior to revocation, will not be affected.

Signature of Consumer: ______________________________ Date: ______________

Signature of Parent/Legal Guardian/Representative: ______________________________ Date: ______________

If you choose to revoke your authorization, please provide a copy of the completed revocation to the Privacy Officer of this facility.