



UPDATE TO AKEELA RESIDENTIAL SERVICES & REFERRAL PROCESS

We would like to share an important update regarding Akeela's residential substance use treatment services, along with updated referral and screening information.

Due to recent changes in the State of Alaska's funding environment, including significant reductions to CBHTR grant funding, Akeela is transitioning our residential programming to better align with current community needs and ensure long-term sustainability of services. These changes will take effect **July 1, 2026**.

What's Changing

- Akeela will no longer be offering SUD residential treatment for women with children residing on-site (Stepping Stones model).
- We recognize the importance of these services and are committed to supporting thoughtful transitions and maintaining strong partnerships with referring agencies who serve this population.

What's Ahead

- Akeela House will serve as our primary site for ASAM 3.5 (Clinically Managed High-Intensity SUD Residential Services).
- Stepping Stones is being restructured into an expanded ASAM 3.1 (Clinically Managed Low-Intensity SUD Residential Services) program with an apartment-style model.
- Both programs will serve adult men and women, expanding access to residential treatment for substance use disorders across levels of care.

This transition strengthens our residential continuum and allows us to better meet the needs of individuals requiring structured substance use treatment services.

Referral Process Updates

We have also updated our residential referral and screening process to improve access and reduce delays:

- In most cases, pre-admission medical clearance and external behavioral health assessments are no longer required **prior** to acceptance.
- Akeela will complete screening to determine appropriateness for residential level of care.
- Additional information may be requested when needed to ensure safe and appropriate placement.

We value our partnership and appreciate your continued collaboration as we implement these changes. Our goal is to maintain timely access to care while ensuring safe, appropriate, and high-quality treatment services. If you have any questions or would like to discuss these updates further, please don't hesitate to reach out at (907) 565-1200.



REFERRAL FOR RESIDENTIAL TREATMENT INSTRUCTIONS

Thank you for your interest in referring an individual to Akeela's Residential Treatment Program. To support timely review and admission, please follow the instructions below.

Akeela uses a no wrong door approach to access services. While completion of the referral form is preferred, referrals may also be initiated by phone based on the individual's or referring party's preference. Our goal is to reduce barriers and support timely connection to care.

How to Submit a Referral

Please complete and submit the Referral & Screening for Residential Treatment Form, which may be completed by the client and/or referring agency or provider. Provide as much information as available to support timely review. Complete details are helpful but not required for review.

Please submit ALL residential referrals to the following:

Email: AkeelaHouseIntake@akeela.org

Phone : 907-565-1200

Additional Documentation

The following supplemental information may be helpful to include with the referral, but is not required in all cases:

- Behavioral Health Assessment and/or ASAM level of care assessment (if available)
- Recent medical evaluations, provider notes, and/or lab results (if available)
- Medical Face Sheet (if available)
- Medication list (if available)
- TB screening results (if available)
- Pregnancy-related medical information (if applicable)
- Court orders or legal documentation (if applicable)

Release of Information (ROI)

A signed Release of Information (ROI) must be included if Akeela will be coordinating with a referring agency or if communication with legal, medical, or community providers is needed.

Screening for Clinical Appropriateness and Safety

Akeela no longer requires a medical evaluation prior to admission. Information provided in the referral and screening process is used to assess clinical appropriateness and ensure we can safely support the individual while maintaining a safe environment for all residents. If concerns are identified, additional information or documentation may be requested prior to admission.

Referral Review Process

Once the referral is received:

1. The referral will be reviewed by Akeela's Residential Referral & Admission Team
2. Additional information or documentation may be requested as needed to support the admission decision.
3. The individual and/or referring agency will be notified of the referral decision.



REFERRAL and SCREENING FOR RESIDENTIAL TREATMENT

The information below may be completed by the client and/or referring agency.

FIRST NAME		MIDDLE NAME	
LAST NAME		MAIDEN NAME	
DATE OF BIRTH	AGE	SOCIAL SECURITY #	
ADDRESS			
CITY		STATE	ZIP CODE
PHONE NUMBER		EMAIL	
REFERRAL SOURCE			
REFERRAL CONTACT		PHONE/EMAIL	
GENDER	RACE & ETHNICITY (Select ALL that apply)		
<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> Transgender Male	<input type="checkbox"/> Other, specify: <input type="checkbox"/> Prefer not to respond	<input type="checkbox"/> Alaskan Native or American Indian (select below) <input type="radio"/> Aleut <input type="radio"/> Athabascan <input type="radio"/> Haida <input type="radio"/> Inupiat <input type="radio"/> Tlingit <input type="radio"/> Tsimshian <input type="radio"/> Yupik <input type="checkbox"/> Other Tribal Affiliation: <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Middle Eastern or Northern African <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other, specify:	
MARITAL STATUS			
<input type="checkbox"/> Cohabiting <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single			
PREFERRED LANGUAGE			
<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> ASL <input type="checkbox"/> Other, list: Interpreter Needed: <input type="checkbox"/> YES <input type="checkbox"/> NO			
PAYER INFORMATION			INSURANCE INFO
<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Other, List: <input type="checkbox"/> Self-Pay <input type="checkbox"/> Tri-Care <input type="checkbox"/> Private, List: <input type="checkbox"/> None			Insurance Subscriber Number:
LEGAL STATUS (Select ALL that apply)			
<input type="checkbox"/> Client has no legal guardian & authorized to make their own decisions <input type="checkbox"/> Client has a court-appointed legal guardian <input type="checkbox"/> Client has a Power of Attorney (POA) <input type="checkbox"/> Client is under Department of Corrections Supervision <input type="checkbox"/> Client has a representative payee or conservator			
LEGAL STATUS CONTINUED			
<input type="checkbox"/> Not Applicable <input type="checkbox"/> Pre-Sentence, In Jail <input type="checkbox"/> DOC Furlough/Parole/Probation <input type="checkbox"/> Incarcerated <input type="checkbox"/> Federal Probation <input type="checkbox"/> Pre-Sentence, Out on Bail/Cust. <input type="checkbox"/> OCS Involvement <input type="checkbox"/> Unknown			
CURRENT/HISTORY LEGAL CHARGES			
			Currently Incarcerated: <input type="checkbox"/> YES <input type="checkbox"/> NO



PRIORITY POPULATION (Select All that Apply)					
<input type="checkbox"/> Injection Drug User (IDU)	<input type="checkbox"/> Significant SUD Risks	<input type="checkbox"/> Pregnant Woman	<input type="checkbox"/> FED Referral		
<input type="checkbox"/> Co-occurring Disorder	<input type="checkbox"/> ASAP Referral	<input type="checkbox"/> Woman with Child	<input type="checkbox"/> None		
<input type="checkbox"/> Therapeutic Court Referral	<input type="checkbox"/> DOC Furlough	<input type="checkbox"/> API Referral			
ASAM LEVEL OF CARE REQUESTED					
<input type="checkbox"/> 3.5	<input type="checkbox"/> 3.1	<input type="checkbox"/> 2.1	<input type="checkbox"/> 1.0	<input type="checkbox"/> SUD & MH Tx	<input type="checkbox"/> Other SUD LOC, List:
SUBSTANCE USE DIAGNOSIS (List All)					
MENTAL HEALTH DIAGNOSIS (List All)					
SI/HI & OTHER IDENTIFIED RISKS					
<input type="checkbox"/> Recent SI Reported	<input type="checkbox"/> Self-Injurious Behaviors	<input type="checkbox"/> Recent Use of Restraints			
<input type="checkbox"/> Recent HI Reported	<input type="checkbox"/> Medication Non-Compliance	<input type="checkbox"/> Other (List):			
<input type="checkbox"/> Hx of SI with Attempt	<input type="checkbox"/> Unmanaged Psychosis	<input type="checkbox"/> No Known Risks			
SUBSTANCE USE					
SUBSTANCE USED	DATE OF LAST USE	AMOUNT	FREQUENCY	ROUTE	WITHDRAWALRISK
SUBSTANCE USE TREATMENT HISTORY					
TREATMENT DATE	PROVIDER & LOCATION	LEVEL OF CARE	OUTCOME OF TX		
RECEIVING MEDICATION ASSISTED TREATMENT (such as buprenorphine or methadone)					<input type="checkbox"/> NO <input type="checkbox"/> YES
MENTAL HEALTH TREATMENT HISTORY					
TREATMENT DATE	PROVIDER & LOCATION	LEVEL OF CARE	OUTCOME OF TX		
Psychiatric Inpatient Hospitalization		<input type="checkbox"/> NO <input type="checkbox"/> YES			
Hospitalization Reason & Dates					
LIVING SITUATION/RECOVERY ENVIRONMENT					
Describe your current living environment and any factors that may impact recovery:					



MEDICAL INFORMATION			
MEDICAL PROVIDER		Date of Last Physical	
ALLERGIES (List All)			
ALL CURRENT MEDICATIONS			
MEDICATION	DOSAGE/FREQUENCY	REASON	
Additional and/or Previous Medication:			
CHRONIC MEDICAL CONDITIONS (Select All That Apply)			
<input type="checkbox"/> Cardiovascular Disease	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> Diabetes (Controlled)	<input type="checkbox"/> Severe Asthma/COPD	<input type="checkbox"/> Autoimmune Disease	
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Cirrhosis/Liver Disease	<input type="checkbox"/> Cancer	
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Stroke	<input type="checkbox"/> Epilepsy/Seizure Disorder	
<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Incontinence	
<input type="checkbox"/> Other Condition, List:	<input type="checkbox"/> HIV+	<input type="checkbox"/> Hepatitis C	
ADDITIONAL MEDICAL INFORMATION & NEEDS (Select All That Apply)			
<input type="checkbox"/> Requires Oxygen	<input type="checkbox"/> Requires Daily Nursing/Medical Care		
<input type="checkbox"/> Requires Daily Wound Care	<input type="checkbox"/> History of Seizures with Withdrawal		
<input type="checkbox"/> Uncontrolled Diabetes	<input type="checkbox"/> Traumatic Brain Injury (TBI)		
<input type="checkbox"/> Specialized Diet	<input type="checkbox"/> Cognitive, intellectual, or developmental condition		
Check YES or NO for Each Item (can be completed by individual and/or referring agency)			
Do you currently have any serious or unstable medical condition that requires regular medical monitoring?			
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown			
Have you been hospitalized or visited the emergency room within the past 30 days for a medical issue?			
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown			
Do you require assistance with mobility or use any medical equipment?			
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown			
Do you currently have a serious infection, open wound, or contagious illness that requires medical treatment?			
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown			
Do you have any medical condition that would limit your ability to participate in daily residential programming?			
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown			
Have you used alcohol or benzodiazepines regularly in the past 30 days?			
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown			
Do you have a history of seizures or seizure disorders?			
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown			
Have you ever experienced severe alcohol or benzodiazepine withdrawal, including seizures or delirium tremens?			
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown			
Are you currently experiencing withdrawal symptoms that may require medical detoxification?			
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown			
Are you currently experiencing suicidal thoughts or a mental health crisis requiring immediate psychiatric care?			
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown			



PREGNANCY SCREENING Not Applicable

Are you currently pregnant or possibly pregnant?
 YES NO Unknown

If pregnant, have you received prenatal medical care during this pregnancy?
 YES NO Unknown

Have you been told by a medical provider that the pregnancy is high-risk or need medical monitoring?
 YES NO Unknown

Have you experienced recent pregnancy complications (bleeding, severe pain, hospitalization, etc.)?
 YES NO Unknown

Are you currently taking medications related to pregnancy or prenatal care?
 YES NO Unknown

If pregnant and using opioids, are you currently receiving medication-assisted treatment (buprenorphine or methadone)?
 YES NO Unknown

Please provide any additional medical information.

CURRENT AGENCY OR LEGAL SUPERVISION

List the community agency, probation/parole officer, child welfare worker, case manager, etc. including their name and contact information. Please ensure that a Release of Information (ROI) has been completed so that Akeela can communicate and coordinate with these agencies.

AGENCY NAME		ROI Completed: <input type="checkbox"/> YES <input type="checkbox"/> NO
PRIMARY CONTACT NAME		
CONTACT INFORMATION		
AGENCY NAME		ROI Completed: <input type="checkbox"/> YES <input type="checkbox"/> NO
PRIMARY CONTACT NAME		
CONTACT INFORMATION		
AGENCY NAME		ROI Completed: <input type="checkbox"/> YES <input type="checkbox"/> NO
PRIMARY CONTACT NAME		
CONTACT INFORMATION		

NAME OF PERSON COMPLETING THIS FORM		SIGNATURE	DATE
RELATIONSHIP	<input type="checkbox"/> Applicant <input type="checkbox"/> Referring Agency <input type="checkbox"/> Other, List		



RESIDENTIAL TREATMENT PROGRAM OVERVIEW

Thank you for your interest in Akeela's Residential Treatment Program. We're hopeful this is the first step toward a healthier, brighter future for you. Before completing the Referral and Screening for Residential Treatment Form, please carefully review the following information to better understand the program expectations, requirements, and available supports throughout treatment.

Akeela's residential programs support individuals in recovery and require commitment and active participation. Akeela provides a continuum of residential substance use treatment services, including ASAM 3.5 (clinically managed high-intensity) and ASAM 3.1 (clinically managed low-intensity) levels of care for adult men and women. ASAM 3.5 is where clients begin building the foundation of recovery in a highly structured setting, while ASAM 3.1 is where clients live and practice recovery with greater independence in an apartment-style setting while building the skills needed to successfully return to the community.

Program Duration

The typical length of stay is approximately 90 days in ASAM 3.5 followed by 90 days in ASAM 3.1, though length of stay may vary based on individual clinical needs. In some cases, additional services may be requested and approved through Alaska's Division of Behavioral Health.

ASAM 3.5 includes a minimum of 20 clinical hours per week, while ASAM 3.1 includes a minimum of 5 clinical hours per week. Throughout treatment, our clinical team provides ongoing support, guidance, and individualized care to help each client progress in their recovery journey.

Medication Policy

Any unauthorized medications, prescription or otherwise, will be confiscated and properly disposed of. Authorized medications will be managed in accordance with your treatment plan.

Substance Use Policy

Total abstinence from all mood-altering substances is required, except for prescribed medications. This is essential to maintaining a sober and supportive environment.

Dress Code

Please wear comfortable and appropriate clothing at all times. Clothing must not display alcohol or drug logos, and no revealing attire is allowed. Socks and shoes are required at all times, and sleeveless tops, tank tops, and open-toed shoes are not permitted in group sessions or outside your living area. During business hours, sweats, and shorts are not allowed.

Personal Belongings

Storage space is limited, so please bring only essential personal items. Pack enough clothing for daily use but avoid bringing excessive belongings, as Akeela is not responsible for lost, stolen, or damaged personal property. We strongly encourage limiting valuable items, including electronics (other than a personal cell phone), jewelry, excessive amounts of cash, gift cards, gaming devices, tablets, laptops, and other items of monetary value.

Orientation Period

Upon admission, a 14-day orientation period is in place to help you acclimate to the program. During this time, you will receive support from peers in the therapeutic community while reading the program handbook and orientation materials. Only business-related phone calls (OCS, attorney, PO) and communication with your children will be allowed during the 14-day orientation period. Staff may assist with approved visits and phone calls during this period.



Phone Calls and Messages

Supported phone calls will be available after you complete the orientation period. Our staff can pass on messages to residents. In case of emergency, your family will be provided with a staff contact number to reach you.

Personal Care Items

Shampoos, mouthwash, hairspray, or other personal care products containing alcohol are prohibited.

Materials Provided

All necessary program materials, such as paper and pens, will be supplied by Akeela.

Parking

Residential client parking is not available. Please do not bring a vehicle to the program.

Tobacco-Free Environment

Akeela's Residential Treatment Programs are completely tobacco/nicotine-free. Tobacco products, including vapes, e-cigarettes, and nicotine patches are **not permitted** on the premises. Smoking cessation support is available, including programs like QuitLine, and staff can assist with arranging services.

Relevant Assistance Programs

Clients may be encouraged to apply for programs such as ATAP, TANF, SNAP, cash assistance, and Medicaid, if eligible. Participation is voluntary and not required for admission or continued treatment. These resources may help cover personal and living expenses during treatment.

Visitation Policy

We believe in the importance of involving supportive family and friends in the recovery process. After the orientation period, visitors are welcome and encouraged. However, they must first attend a visitation orientation group and participate in a meeting with the client's primary counselor.

RESIDENTIAL APPLICANT RESPONSIBILITIES & AGREEMENT

Health and Readiness for Admission

To be admitted into the program, you must be stable enough to safely participate in treatment. If you arrive under the influence of alcohol or other substances, or if you are in withdrawal and require clinical intervention, you will be referred to an appropriate detoxification facility before entering our program.

Responsibility for Personal Costs

Akeela's Residential Treatment Programs are not responsible for transportation or any personal expenses you may incur during treatment. This includes costs for approved medications, personal items, and other necessary expenses.

Medication Requirements

If you are taking prescribed medications, please bring them with you in their original prescription bottles. Each medication must have the original pharmacy label with the prescription details. Medications cannot be mixed together in other containers or pill organizers.



Treatment Fees and Payment

Treatment fees are determined using a sliding fee scale based on your income and family status, in accordance with federal poverty guidelines. This ensures that fees are fair and appropriate to your financial situation.

Service Authorization Requirements (Alaska Medicaid 1115 SUD Waiver)

Individuals with Medicaid may receive up to 90 days of residential treatment at ASAM Level 3.1 and 90 days at Level 3.5 each fiscal year (July 1 – June 30) without prior authorization. If you have already received residential treatment at either level during the current fiscal year, you must report this on the Residential Applicant Responsibilities Agreement to support proper authorization and continuity of care.

Prior Treatment:

Have you received residential substance use treatment at Level 3.1 or 3.5 at any other facility since July 1 of this fiscal year? YES NO

If **YES**, please complete the following:

Facility Name	Location	Level of Care	Admission Date	Discharge Date

Acknowledgement:

By submitting your application for residential treatment at Akeela and signing below, you acknowledge that:

- I certify that the information provided in this referral and screening form is true and accurate to the best of my knowledge, whether completed by myself or on my behalf.
- I have signed a Release of Information (ROI) allowing Akeela to obtain additional information needed to determine my eligibility for treatment and to coordinate my admission.
- Additional Releases of Information may be required for other agencies (Attorney, PO, Courts, OCS, etc.) to support coordination and ensure appropriate placement in the program.
- I have read the **Residential Treatment Program Overview** and agree to the enclosed **Residential Applicant Responsibilities Agreement**

APPLICANT SIGNATURE	DATE



AUTHORIZATION FOR RELEASE OF INFORMATION

CLIENT INFORMATION				
LAST NAME	FIRST NAME	MIDDLE NAME	DOB	PHONE#

I HEREBY REQUEST/AUTHORIZE RECORDS TO BE SENT:			
<input type="checkbox"/> TO <input type="checkbox"/> FROM <small>Must check one</small>	NAME OF PERSON/AGENCY	ADDRESS	CITY, STATE, ZIP CODE
<input type="checkbox"/> TO <input type="checkbox"/> FROM <small>Must check one</small>	AKEELA, INC	360 WEST BENSON BLVD	ANCHORAGE, AK 99503

TIMEFRAME FOR RECORDS: Specify the dates of service or time period for the records you want released.			
START DATE or TIME PERIOD/YEAR:		END DATE or TIME PERIOD/YEAR:	
TYPE OF RECORDS TO BE RELEASED: Select the specific types of information you authorize for release. INITIAL ALL that apply.			
<input type="checkbox"/> INITIAL	Admission Assessment	<input type="checkbox"/> INITIAL	Treatment or Discharge Summary
<input type="checkbox"/> INITIAL	Attendance History	<input type="checkbox"/> INITIAL	Client in Treatment Confirmation
<input type="checkbox"/> INITIAL	Mental Health Only Assessment	<input type="checkbox"/> INITIAL	Psychiatric Evaluation
<input type="checkbox"/> INITIAL		<input type="checkbox"/> INITIAL	Progress Notes
<input type="checkbox"/> INITIAL		<input type="checkbox"/> INITIAL	Lab/Drug Screening Results
<input type="checkbox"/> INITIAL		<input type="checkbox"/> INITIAL	Other (specify):
<input type="checkbox"/> INITIAL		<input type="checkbox"/> INITIAL	Treatment Plan/Updates
<input type="checkbox"/> INITIAL		<input type="checkbox"/> INITIAL	Leave a Message for Client/Correspondence

DELIVERY OF RECORDS: Please select how you would like your records to be delivered. Check ALL that apply		
<small>*Email poses privacy risks, consider carefully before authorizing.</small>		
<input type="checkbox"/> Fax (List Fax Number):	<input type="checkbox"/> Verbal	<input type="checkbox"/> Exchange Information Between Parties
<input type="checkbox"/> *Email (List Email Address):	<input type="checkbox"/> Mail Documents	<input type="checkbox"/> I Will Pick up Records

PURPOSE OF RELEASE: Check ALL that apply.		
<input type="checkbox"/> Coordination of Care	<input type="checkbox"/> Further Treatment	<input type="checkbox"/> My personal records
<input type="checkbox"/> Share with other health care providers	<input type="checkbox"/> Legal	<input type="checkbox"/> Other (specify):

AUTHORIZATION ACKNOWLEDGEMENT & CONSENT: Please read the statement below carefully. By signing at the end of this form, you are confirming that you understand and agree to the terms described. This authorization will expire at the time of discharge from services or 12 months from the date signed, whichever is sooner.

I understand that my health records may include sensitive information such as diagnoses or treatment related to behavioral health, mental health, substance use, alcohol or drug treatment, and information related to HIV/AIDS. I understand that disclosing this information may be necessary to support coordination of care between providers. I acknowledge that choosing not to share this information may affect the quality or continuity of my care. I voluntarily authorize the use and/or disclosure of my health information as described in this release. I understand that this authorization is not required as a condition for receiving treatment, payment, enrollment in a health plan (if applicable), or eligibility for benefits. I understand that if the person or organization authorized to receive this information is not a health care provider or health plan, the information disclosed may no longer be protected under federal privacy laws. However, I also understand that certain types of information, such as substance use treatment records, may still be protected under federal or state confidentiality laws and must continue to be kept confidential by the recipient. I acknowledge that my substance use treatment records are protected under federal law by 42 CFR Part 2 and under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164. These records may not be disclosed without my written consent, unless otherwise permitted or required by law.

RIGHT TO REVOKE: I understand that I have the right to revoke this authorization at any time. I understand that the revocation will not apply to any information that has already been disclosed or actions already taken in reliance on this authorization prior to the date the revocation is received. To revoke this authorization, I must submit my request in writing to Akeela by mail at 360 W. Benson Blvd. Suite 300, Attention: Privacy Officer, Anchorage, AK 99503, in person, or via secure portal message.

CLIENT SIGNATURE	DATE
CLIENT GUARDIAN/REPRESENTATIVE SIGNATURE (if applicable)	DATE

RECIPIENT INFORMATION - REDISCLOSURE NOTICE: This record which has been disclosed to you is protected by Federal confidentiality rules (42 CFR part 2). These rules prohibit you from using or disclosing this record, or testimony that describes the information contained in this record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against the patient, unless authorized by the consent of the patient, except as provided at 42 CFR 2.12(c)(5) or as authorized by a court in accordance with 42 CFR 2.64 or 2.65. In addition, the Federal rules prohibit you from making any other use or disclosure of this record unless at least one of the following applies: (i) Further use or disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or as otherwise permitted by 42 CFR part 2. (ii) You are a covered entity or business associate and have received the record for treatment, payment, or health care operations, or (iii) You have received the record from a covered entity or business associate as permitted by 45 CFR part 164, subparts A and E. A general authorization for the release of medical or other information is NOT sufficient to meet the required elements of written consent to further use or redisclose the record (see 42 CFR 2.31).