



260 Oak Street
 Sudbury, Ontario
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CONSENT FOR RELEASE / REQUEST OF CONFIDENTIAL INFORMATION

Participant's Name: _____ Date of Birth: _____
Please Print Day Month Year

Having read and understood this form, I hereby authorize **MONARCH RECOVERY SERVICES** to RELEASE and/or OBTAIN the following information to/from the person/agency listed.

Person/ Agency Name	YES	NO	INITIALS
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Mandatory Contact Information Tel.: (____) _____ Fax.: (____) _____

In order for this release to be valid, one column (Yes or No) must be checked and initialed by the participant for each area of disclosure.

AREA OF DISCLOSURE:	YES	OR	NO	INITIALS
1. Confirmation of Attendance/Completion	1. <input type="checkbox"/>		1. <input type="checkbox"/>	1. _____
2. Assessment and Treatment Planning Information	2. <input type="checkbox"/>		2. <input type="checkbox"/>	2. _____
3. Discharge Summary	3. <input type="checkbox"/>		3. <input type="checkbox"/>	3. _____
4. Progress Reports	4. <input type="checkbox"/>		4. <input type="checkbox"/>	4. _____
5. Legal Status (i.e. court cases, parole, probation)	5. <input type="checkbox"/>		5. <input type="checkbox"/>	5. _____
6. All information pertaining to Methadone/Suboxone	6. <input type="checkbox"/>		6. <input type="checkbox"/>	6. _____
7. Emergency Contact Only	7. <input type="checkbox"/>		7. <input type="checkbox"/>	7. _____
8. Other (specify) _____	8. <input type="checkbox"/>		8. <input type="checkbox"/>	8. _____

Consent includes the electronic storage and transmission of files containing personal health information. YES NO

If request obtained verbally, specify details (i.e. date, time, method, etc.):

In order for this release to be valid this form must be completed in its entirety.

Participant Signature: _____ Date: _____

Witness Signature: _____ Date: _____

This consent shall expire once the person has completed their service or upon discharge. This does not include the electronic storage of information, which must be kept for 10 years.