Insurance? [ ] Yes [ ] NO | Member ID# | Phone # on back of INS card: | Date: / /

CLIENTS NAME: | PHONE #

Have you ever been a Client At CCS? YES- NO | VITALS: BP: / Pulse: Temp: | Sex Offender? YES-NO

Age: | DOB: | SS#: | Marital Status: | US Citizen: YES- NO

Tennessee Resident: [ ] Yes [ ] NO | Are you a Veteran: [ ] Yes[ ] No | DUI: [ ] Yes [ ] NO | Gender: [ ]Male [ ]Female

Race: [ ] White [ ] Black [ ] Hisp/Lat. | Number of Children: | Ages & Gender of Children:

Who has Custody? | Your Education Level:

Homeless [ ] Yes [ ] NO | If yes, indicate previous address below | COMMIT TO TX [ ] Yes [ ] NO

Client Permanent Address (or previous address if homeless):

City: | State: | Zip:

Phone: [ ] | County: | Referral Source Name:

Relationship to Referral:

Are you on Social Security: [ ] Yes [ ] No | SSI: [ ] Yes [ ] No | Do you have any Physical Disabilities: [ ] Yes [ ] No

Employed: [ ]Yes [ ]No | If yes Where? | Job Description: | How Long?

Monthly Income: | Income Source(s):

Do you have a Valid Driver's License: [ ] Yes [ ] No | Is this court ordered? [ ] Yes [ ] No | On Probation/Parole:[ ] Yes [ ] No

P.O./CM Name: | Notify court or P.O. if discharged early: [ ]Yes [ ]No

P.O./CM Phone #: | Probation Company:

The number of arrests in the 30 days prior to admission? [ ] | Current Legal Issues:

Previous Alcohol or Drug Treatment History (when/where)?

Reason For Treatment (what happened recently) Presenting Problem:

| Name of Problem Substance | Prescribed Y/N | Date last Used | Dosage | Rating (1st,2nd,etc.) | Duration (How long) | Route | Frequency | Age of 1st Use |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

IV Drug Use: [ ] Yes [] No | Pregnant: [ ]Yes [ ]No Due Date: | Priority Status: [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6

Medical Problems (past and/or present): | Any Detox Symptoms?[ ] Yes[ ] No | Any Allergies:

Medications taking for medical problems: | History of seizures:[ ] Yes [ ] No

Have you ever tested positive for T.B.? [ ] Yes [ ] No | If Yes, When/Where?

Last Physical Exam: | Primary Care Physician: | Phone:

Psychiatric Treatment (past and/or present): [ ] Yes [ ] No | If Yes, Diagnosis:

Prescribed medication for psychiatric Problem:

How long have medications been taken? | How long has medications been stopped?

Suicidal ideations/attempts (when)? | Did you have a | Current Living Situation:

How long have you been there? | Living Plans on discharge:

Is there drinking/drug use going on? [ ]Yes [ ]No | Same [ ] | Family [ | Halfway House [ ]

Emergency Shelter Needed? [ ] Yes [ ] No | Other [ ] | Undecided

Transportation needed to/from treatment? [ ]Yes [ ]No | Housing Needed? [ ]Yes [ ] No

Address/directions to pick-up location: | Level of care screened for: [ ] DETOX [ ] RTC [ ] IOP[ ] OP

Payer Source: [ ] BG | [ ] CTC | [ ] SOR | [ ] ADAT | [ ] SPOT | [ ] ARP | [ ] ADOL | [ ] INS | [ ] Self-Pay

| Emergency/Alt. Contact | Address/City/State/ Zip | Phone | Relation |
|---|---|---|---|
| | | | |
| | | | |

| Date of Contact: | Type of Contact Made: | Date of Contact: | Type of Contact Made: |
|---|---|---|---|
| re: waiting list | [ ] Phone [ ] Letter [ ] Other | re: waiting list | [ ] Phone [ ] Letter [ ] Other |

Agency Referred to: | [ ]Health Dept | [ ]12 Step AA | [ ]Hospital | [ ] Outpatient Counseling | [

Details of Referral (Agency Name/Contact Information

Date Interim Service Began: | Type of Interim Service:

Screened By: | Actual Admit Date: | Date ASI Scheduled:

Final Disposition: Admitted [ ] Yes [ ] No -- Referred [ ] | Family Member/PO Notified: [ ]Yes [ ] No If so, who was notified?

Additional Comments: (Include any problems that would interfere with Tx such as court date, Dr. apt., etc)

Informed client of call in procedures; call in weekly your bed date may be given to someone else. Admission Initials. ________________ RE:1/1/2024

**Infectious Disease Screening Form**

Patient Name ___________________________

1. To be admitted to our facility, we require a current measure of your body temperature. If you have a temperature of 100.4F or greater, you will not be allowed to enter the facility.
Do you give the facility permission to obtain this information?
Yes ☐ No: ☐ Temperature Results: ____________

2. Do you or have you had signs and symptoms of a respiratory illness within the past 14 days? (**Fever or chills, Cough, Shortness of breath or difficulty breathing, Fatigue, Muscle or body aches, Headache, New loss of taste or smell, Sore throat, Congestion or runny nose, Nausea or vomiting, Diarrhea**)
Yes ☐ No: ☐

3. Have you been tested for COVID-19/RSV/FLU? Yes ☐ No: ☐
If yes what were the results?Negative: ☐ Positive: ☐ Date of test ___________

4. Have you been in contact with someone who has or has had a respiratory illness within the last 14? Yes ☐ No: ☐

5. Look for emergency warning signs for respiratory illnesses and report them to staff if you or someone else is having any of the following symptoms: (**Trouble breathing, Persistent pain or pressure in the chest, New confusion, Inability to wake or stay awake, Bluish lips or face**)

6. While receiving services at CCS you will need to follow the CDC recommendations of:

- **Wash your hands often** for at least 20 seconds.
- Cover your cough or sneeze with a tissue, then throw the tissue in the trash.
- **DO** wear a mask when in groups or around staff while experiencing any respiratory symptoms.
- Clean and disinfect frequently touched objects.
- Stay home when you are sick. Do not come to treatment if sick, you will not be admitted.
- Contact a care worker if you have **symptoms**; fever and a dry cough are most common.
- **DON'T** touch your face.
- **DON'T** travel if you have a fever and cough.

Patient Signature:_____________________________________________Date: ____________________

Guardian Signature:___________________________________________Date: ____________________

Staff Signature:_______________________________________________Date: ____________________

Revised on January 1, 2024

Patient #_________

**Mental Health Screening Form-III**

Instructions: Read each question and circle the appropriate response. Please note, each item refers to your entire life history, not just your current situation. This is why each question begins with "Have you ever….."

1. Have you ever talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem?

YES NO

2. Have you ever felt you needed help with your emotional problems, or have you had people tell you that you should get help for your emotional problems?

YES NO

3. Have you ever been advised to take medication for anxiety, depression, and/or hearing voices or for any other emotional problem?

YES NO

4. Have you ever been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons?

YES NO

5. Have you ever heard voices no one else could hear or seen objects or things which others could not see?

YES NO

6. Have you ever been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions, or thought about killing yourself?

YES NO

7. Have you ever attempt to kill yourself?

YES NO

8. Have you ever experienced any strong fears? For example, of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help?

YES NO

9. Have you ever given in to an aggressive urge or impulse, on more than one occasion that resulted in serious harm to others or led to the destruction of property?

YES NO

10. Have you ever felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behaviors?

YES NO

11. Have you ever experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner? YES NO

Patient #_________

12. Have you ever had a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating? For example, by repeatedly dieting or fasting, engaging in much exercise to compensate for binge eating, taking enemas, or forcing yourself to throw up?

YES NO

13. Have you ever had spells or attacks when you suddenly felt anxious, frightened, uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset, you felt dizzy or unsteady, as if you would faint?

YES NO

14. Have you ever had a period of time when you were so full or energy and your ideas came very rapidly, when you talked nearly non-stop, when you moved quickly from one activity to another, when you needed little sleep, and believed you could do almost anything?

YES NO

15. Have you ever had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work, or your social relations? For example, repeatedly counting things, checking and rechecking on things you had done, washing and rewashing your hands, praying, or maintaining a very rigid schedule of daily activities from which you could not deviate?

YES NO

16. Have you ever lost considerable sums of money through gambling or had problems at work, in school, with your family and friends as a result of your gambling?

YES NO

17. Have you ever been told by teachers, guidance counselors, or others that you have a special learning problem?

YES NO

Comments:____________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

Total Score of YES responses _________ If you have checked more than three Yes remarks, it is suggested to contact a mental health provider. Would you like to be referred for an Psychiatric Evaluation: (Circle one) Yes No

Patient Signature: ____________________________________________ Date: ____________

Guardian Signature: ___________________________________________ Date: ____________

Witness Signature: ____________________________________________ Date: ____________

# Short Michigan Alcoholism Screening Test (SMAST)

Patient # ________

The following questions concern information about your involvement with alcohol during the past 12 months. Carefully read each question and decide if your answer is "YES" or "NO". Then, check the appropriate box beside the question.

| **<u>These questions refer to the past 12 months only.</u>** | **YES** | **NO** |
|---|---|---|
| 1. Do you feel you drink more than most other people?……………………….. | ☐ | ☐ |
| 2. Does your partner or parents worry or complain about your drinking?........... | ☐ | ☐ |
| 3. Do you ever feel guilty about your drinking?.................................................. | ☐ | ☐ |
| 4. Do friends or relatives think you drink **more** than most other people?............ | ☐ | ☐ |
| 5. Have you ever tried to stop drinking but were not able to do so?..................... | ☐ | ☐ |
| 6. Have you ever attended a meeting of Alcoholics Anonymous (AA)?.............. | ☐ | ☐ |
| 7. Has drinking ever created problems between you and your partner or parents? | ☐ | ☐ |
| 8. Have you ever gotten into trouble at work because of your drinking?............. | ☐ | ☐ |
| 9. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?................... | ☐ | ☐ |
| 10. Have you ever sought help for your drinking?.............................................. | ☐ | ☐ |
| 11. Have you ever been hospitalized because of drinking?.................................. | ☐ | ☐ |
| 12. Have you ever been arrested or ticketed for drunk driving (DUI or DWI) or driving after drinking?...................................................................... | ☐ | ☐ |
| 13. Have you ever been arrested, even for a brief time, for other drunken behavior? | ☐ | ☐ |
| *** SMAST Score**……………………………… Total | _____ | _____ |

***Each yes equals (1) point.***

| | | |
|---|---|---|
| *0-2* | *No problems reported* | *None at this time.* |
| *3* | *Borderline alcohol problem reported* | *Further investigation is required.* |
| *4 or more* | *Potential Alcohol Abuse reported* | *A full assessment is required.* |

Patient Signature: ____________________________________ Date: ____________________

Guardian Signature: ____________________________________ Date: ____________________

Witness Signature: ____________________________________ Date: ____________________

Revised January 1, 2024

# Drug Abuse Screening Test, DAST-10

The following questions concern information about your possible involvement with drugs ***not including alcoholic beverages*** during the past 12 months. "Drug abuse" refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions, and (2) any nonmedical use of drugs. The various classes of drugs may include cannabis (marijuana, hashish), solvents (e.g., paint thinner), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions *do not* include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

| **In the past 12 months…** | | **Circle** | |
|---|---|---|---|
| 1. | Have you used drugs other than those required for medical reasons? | Yes | No |
| 2. | Do you abuse more than one drug at a time? | Yes | No |
| 3. | Are you unable to stop abusing drugs when you want to? | Yes | No |
| 4. | Have you ever had blackouts or flashbacks as a result of drug use? | Yes | No |
| 5. | Do you ever feel bad or guilty about your drug use? | Yes | No |
| 6. | Does your spouse (or parents) ever complain about your involvement with drugs? | Yes | No |
| 7. | Have you neglected your family because of your use of drugs? | Yes | No |
| 8. | Have you engaged in illegal activities in order to obtain drugs? | Yes | No |
| 9. | Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? | Yes | No |
| 10. | Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)? | Yes | No |
| **Scoring:** Score 1 point for each question answered "Yes," except for question 3 for which a "No" receives 1 point. | | **Score:** | |

| **Interpretation of Score** | | |
|---|---|---|
| **Score** | **Degree of Problems Related to Drug Abuse** | **Suggested Action** |
| 0 | No problems reported | None at this time |
| 1-2 | Low level | Monitor, re-assess at a later date |
| 3-5 | Moderate level | Further investigation |
| 6-8 | Substantial level | Intensive assessment |
| 9-10 | Severe level | Intensive assessment |

Patient Signature: ______________________________ Date: ________________

Guardian Signature: ______________________________ Date: ________________

Witness Signature: ______________________________ Date: ________________

**LIFE EVENT CHECKLIST (TRAUMA SCREEN)**

Patient #_____________

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it happened to you personally, (b) you witnessed it happen to someone else, (c) you learned about it happening to someone close to you, (d) you're not sure if it fits, or (e) it doesn't apply to you. Be sure to consider your entire life (growing up as well as adulthood) as you go through the list of events.

| Event | Happened to me | Witnessed it | Learned about it | Not Sure | Doesn't apply |
|---|---|---|---|---|---|
| 1. Natural disaster (for example, flood, hurricane, tornado, earthquake) | | | | | |
| 2. Fire or explosion | | | | | |
| 3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash) | | | | | |
| 4. Serious accident at work, home, or during recreational activity | | | | | |
| 5. Exposure to toxic substance (for example, dangerous chemicals, radiation) | | | | | |
| 6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up) | | | | | |
| 7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb) | | | | | |
| 8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm) | | | | | |
| 9. Other unwanted or uncomfortable sexual Experience | | | | | |
| 10. Combat or exposure to a war-zone (in the military or as a civilian) | | | | | |
| 11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war) | | | | | |
| 12. Life-threatening illness or injury | | | | | |
| 13. Severe human suffering | | | | | |
| 14. Sudden, violent death (for example, homicide, suicide) | | | | | |
| 15. Sudden, unexpected death of someone close to you | | | | | |
| 16. Serious injury, harm, or death you caused to someone else | | | | | |
| 17. Any other very stressful event or experience (including any abuse and neglect) | | | | | |

Patient Signature: ___________________________________ Date: _____________________

Witness Signature: __________________________________ Date: _____________________

# COLUMBIA-SUICIDE SEVERITY RATING SCALE

*Screen Version with Triage Points*

Client #: ____________________

| SUICIDE IDEATION DEFINITIONS AND PROMPTS: | Past month | |
|---|---|---|
| **Ask questions that are in bold and underlined.** | **YES** | **NO** |
| **Ask Questions 1 and 2** | | |
| **1) Wish to be Dead:**<br>Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up?<br>***Have you wished you were dead or wished you could go to sleep and not wake up?*** | | |
| **2) Suicidal Thoughts:**<br>General non-specific thoughts of wanting to end one's life/commit suicide, "*I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan*."<br>***Have you had any actual thoughts of killing yourself?*** | | |
| **If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.** | | |
| **3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act):**<br>Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "*I thought about taking an overdose, but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*"<br>***Have you been thinking about how you might do this?*** | | |
| **4) Suicidal Intent (without Specific Plan):**<br>Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as oppose to "*I have the thoughts, but I definitely will not do anything about them.*"<br>***Have you had these thoughts and had some intention of acting on them?*** | | |
| **5) Suicide Intent with Specific Plan:**<br>Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.<br>***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*** | | |
| **6) Suicide Behavior Question**<br>***Have you ever done anything, started to do anything, or prepared to do anything to end your life?***<br>Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.<br>**If YES, ask:** ***Was this within the past 3 months?*** | **Lifetime** | |
| | | |
| | **Past 3 Months** | |
| | | |

**Response Protocol to C-SSRS Screening** (Linked to last item marked "YES")
**Item 1** Behavioral Health Referral at Discharge
**Item 2** Behavioral Health Referral at Discharge
**Item 3** Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
**Item 4** Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions
**Item 5** Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions
**Item 6** Over 3 months ago: Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
**Item 6** 3 months ago or less: Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions

- ☐ Disposition: Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions
- ☐ Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
- ☐ Behavioral Health Referral at Discharge
- ☐ **IF YES IS MARKED FILL OUT C-SSRS (7c) FORM (2) PAGE RATING SCALE, NOTING DISPOSITION.**

Staff Completing Form: ________________________________________ Date: ____________________

Reviewed by Clinical Director: ____________________________________ Date: ____________________

Revised January 1, 2024

## APPROVED ITEMS TO BRING TO CCS

Patient # ____________________

| **CLOTHING**: | **MEDICATIONS:** |
|---|---|
| (5) Pairs of long pants (no holes, no shorts, no leggings)<br>(8) Shirts (Hoodies or tee shirts, no tank tops, spaghetti straps, no A-Shirts)<br>(2) Pair of shoes<br>(1) Pair of shower shoes<br>(5) Pair of socks<br>(5) Pairs of underwear includes Bras for women<br>(2) Set of sleepwear (No Shorts or nightgowns)<br>(1) Jacket<br>**No shorts, sleeveless shirts, purses, hats or headgear, earrings*** NO BODY JEWELRY*****<br>**(no offensive images or words; all shirts must have sleeves)**<br>**Do not bring Expensive clothing, jewelry, etc. and/or large sums of money** | Bring (30) Day Supply of approved medications, or valid refills or a new Rx that you can pay for. **You are responsible for payment of your medications**.<br>**NO over the counter medications**, **unless prescribed**.<br><br>**NOTE**: Patients reporting without a (30) day supply of their medications will NOT be admitted.<br><br>**Medications must be in the appropriate container with patient and Doctor's name on the label. Medications will be verified.**<br><br>**NO UNAUTHROIZED MEDICATION WILL BE ALLOWED AND YOU MAY NOT BE ADMITTED IF YOU TRY TO BRING IN!!!** |
| **MISCELLANEOUS ITEMS:** | **HYGIENE:** |
| Bible & (2) recovery related books<br>Valid Tennessee Photo ID.<br>Parole/Probation Officer's information.<br>Stamps and envelopes, notebook paper, pen and pencil.<br>Money for snacks and Pay Phone, Or a Phone Card<br>Cigarettes to Last 4 weeks (patients can **NOT** roll their own cigarettes) **NO TOBACCO UNDER 18!!!!**<br>**No Smokeless Tobacco. NO E-Cigarettes, NO VAPING**<br>**NO** Personal Electronics (IPODS, Cell Phones)<br>**NO** Puzzle or fiction books<br>**NO** Magazines<br>**NO Matches or lighters**<br>**NO WEAPONS OF ANY KIND!!!** | Toothpaste, shampoo, conditioner, deodorant, body soap or wash, shaving cream **HAS TO BE ALCOHOL FREE**<br>Toothbrush<br>Disposable Razors<br>Electric Razor, clippers, Hair Dryer, Curling Iron (if the UL approved tag is Attached)<br>Brush, comb, nail clippers<br>Women: Basic, up to (7) make up items<br>Laundry Detergent for your laundry<br>**NO Aerosol cans such as: Aerosol deodorant, Hairspray, Lysol, Bug spray** |

**!!!!!!!!!!!!!!!PATIENTS ARE NOT ALLOWED TO PARK A CAR AT CCS!!!!!!!!!!!!!!!**

ALL towels, bed linens, pillows, and laundry machines are provided by CCS

I have been informed (or referral source was informed) of what is acceptable and what is not allowed to bring to residential treatment with me. I understand that CCS will not be responsible for storage of any items that are not on the approved list. All clothing must be machine washable. Do not bring expensive clothing, CCS is not responsible for your clothing. Items that do not list ingredient content are unacceptable. Any unsealed tobacco items and unapproved or excess items that are brought in will be disposed of immediately or returned to the transporter if possible**. Any items left when client leaves will be disposed of after 30 days.**

Patient Signature: ______________________________ Date: ______________

Guardian Signature: ______________________________ Date: ______________

Witness Signature: ______________________________ Date: ______________

Revised January 1, 2024

**AUTHORIZATION TO EXCHANGE INFORMATION**
**FOR ALCOHOL AND DRUG TREATMENT PROGRAM**

Sections 1-4 must be completed for this release to be valid

6145 TEMPLE STAR ROAD
KINGSPORT TENNESSEE 37660
423-349-4070 Fax: 423-349-6597

_____/_____Client received a copy of this completed release

_____/_____Client declined a copy of this completed release

______ I'm refusing to sign consent to release information to any previous/current medical or mental health care professional.

**Section 1:**

I, ________________________________________________________SS#_________________________________DOB:______________________,

Authorize the following organization and/or person(s) to exchange information with Comprehensive Community Services, 6145 Temple star Road, Kingsport Tennessee, 37660

__________ ____________________________________________
Name of Organization/Person(s)-Required

_______________________________________________
Relationship/Title

______________________________________________________________________________________________________________________
Address of Organization (including City, State, Zip Code)-REQUIRED

Telephone Number: ________________________ Fax Number: _________________________

**Section 2:**
For what purpose is this information being requested (Required): Admission, Coordination of Care, After Care and Follow Up Treatment

**Section 3:**
INFORMATION TO BE RELEASED: (This section is REQUIRED. Only specified information will be released. Requests for "any/or All records" will not be honored) Circle one.

| | | |
|---|---|---|
| [Y N ] Admission Summary | [Y N ] Preadmission Assessment | [Y N ] Medical Records |
| [Y N ] Treatment Plans | [Y N ] This Completed Release Form | [Y N ] Disciplinary Reports |
| [Y N ] Weekly Case Reviews | [Y N ] Social History | [Y N ] Aftercare Plan |
| [Y N ] Pre-Admission | [Y N ] Verbal Progress Reports | [Y N ] Discharge Summary |
| [Y N ] A.S.I | [Y N ] Medication History | [Y N ] Other______________________ |
| [ ] Verify Admission | [ ] ADAT, SPOT, BG, ARP, INS, SELF | [Y N ] Yes on all |

THE ABOVE INFORMATION IS NECESSARY FOR THE FOLLOWING PURPOSES (CHECK EACH APPLICABLE CATEGORY):

| | | |
|---|---|---|
| [Y N ] Follow-Up Treatment/Aftercare | [Y N ] Family/Significant Other Involvement | [Y N ] Further Evaluation |
| [Y N ] Referral Source Feedback | [Y N ] Coordination of Care with Physician | [Y N ] Other:_________________ |
| [Y N ] Legal Involvement/Follow-Up | [Y N ] Diagnosis and Treatment | [Y N ] Yes on all |

**Section 4:** I understand that my alcohol and/or drug treatment records are protected under Federal regulations governing Confidentiality and Drug Abuse Client records, 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 C.F.R. Parts 160 & 164. I understand that my health information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may re-disclose the information and it may no longer be protected by the HIPPA Privacy Law. The federal regulations governing Confidentiality of Alcohol and Drug Abuse Client Records, 42 C.F.R.; Part 2, noted above however, will continue to protect the confidentiality of information that identifies me as a Client in an alcohol or other drug program from re-disclosure. I understand that I may revoke this consent at any time except to the extent that action based on this consent has been taken in reliance on it. This consent will expire automatically after 365-days from the date which it is signed and is subject to revocation at any time except to the extent that action has already been taken in reliance thereon and a specified date. Event or condition upon which the consent will expire without express revocation. This release is only valid for this admission, no prior or future admissions. I hereby release Comprehensive Community Services, the administrator, personnel, staff, and the organization stated above from all legal responsibilities or liability that may arise from the release of such records. I also acknowledge the understanding that this release does not interchange for the release of information from any other treatment programs. I also understand that generally, Comprehensive Community Services, may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. This authorization to obtain and release information is fully understood and is voluntary on my part.

Patient Signature: ___________________________________ Date: ___________________

Witness Signature: __________________________________ Date: ___________________

Date Revoked:___________________

By Whom: ______________________

Staff: _________________________

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42 CFR Part 2 ) prohibits you from making any further disclosure of this information without the express written consent of the individual to whom it pertains, except in emergency conditions specified by those regulations. A general release or generic release for medical or other information is NOT sufficient for this purpose.

Revised January 1, 2024