# Appendix B

# Consent, Confidentiality, Principles of Conduct, and Client Rights Forms

## CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____hereby authorize

_____ to release to

_____for the purpose of _____

_____the following information:

_____

_____

_____

I understand that my records are protected under the Federal and state confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g., probation, parole, etc.), and that in any event this consent expires automatically in 90 days unless otherwise specified below.

Other expiration specifications:_____

Date executed: _____

Signature of client:_____

Signature of witness:_____

## CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE CLIENT RECORDS

The confidentiality of alcohol and drug abuse client records maintained by this program is protected by Federal law and regulations. Generally, the program may not say to a person outside the program that a client attends the program or disclose any information identifying a client as participating in an alcohol or drug abuse program UNLESS—

1. the client consents in writing; or

2. the disclosure is required by court order; or

3. the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation; or

4. the client commits or threatens to commit a crime either at the program or against any person who works for the program.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs.

Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

I have read, understand, and received a copy of the above statement.

_____ _____

Client signature Date

_____ _____

Witness signature Date

## PRINCIPLES OF CONDUCT

As a client of this program, you are expected to behave at all times in accordance with our Principles of Conduct. If for any reason you fail to follow these principles, you may be asked to leave the program so that your behavior does not become a barrier to the recovery of others.

Our Principles of Conduct are as follows:

1. I will be honest about matters related to my recovery.
2. I will sincerely attempt to understand my addictions problem.
3. I will follow the directives and advice offered by the staff.
4. I will not use drugs or alcohol at any time during the program. (Clients taking prescribed medications will be allowed to participate in the program with the approval of the Director.)
5. I will submit to breath tests or random urine drug screening or searches when asked.
6. I will honor the confidentiality and rights of other clients, staff, and volunteers.
7. I will be considerate and respectful of other clients, staff, and volunteers.
8. I will not engage in or tolerate violence, threats of violence, and/or antisocial behavior.
9. I will not engage in sexual contact of any kind—physical or verbal—with others in the program, the staff, or volunteers.
10. I will be on time for all meetings and sessions assigned by my Counselor, except when excused for good reason in advance by the Director of the program.
11. I will not smoke during group sessions.
12. I will not eat or drink during group sessions.

The Principles of Conduct have been clearly read and explained to me. I have been given a copy for my own use. My signature below is an acknowledgement that I understand and agree to abide by these Principles of Conduct.

_____ _____

Client Signature and Date Staff Person Signature and Date

## CLIENT RIGHTS

1. You have the right to treatment without regard to race, religion, sex, ethnic background, age, sexual orientation, physical disability, employment status, insurance coverage, or any other nonclinical reason.

2. You have the right to professional, committed, and qualified services.

3. You have the right to be informed about all program policies which affect the course of your treatment.

4. You have the right to confidentiality of your treatment record, except in case of medical emergency or court order.

5. You have the right to participate with your Counselor in your treatment plan and in other decisions that will establish your treatment goals.

6. You have the right, with specific limitations, to see your own treatment record.

7. You have the right to be treated with dignity and respect.

8. You have the right to question any aspect of your treatment experience.

You have the responsibility to protect your rights. If at any time you believe your rights have been violated, please contact the Director of the program immediately.

My rights have been clearly read and explained to me. I have been given a copy for my own use. My signature below is an acknowledgement that I understand my rights.

_____ _____

Client Signature and Date Staff Person Signature and Date

*U.S. G.P.O.:1995-399-274S