Stay Designated Inc.

**Authorization for Exchange of Confidential Information**

**Chances for Change Program**

NAME: _____

DOB: _____

SSN: _____

By signing this document, I (Client/Guardian name) _____ herby authorize Stay Designated, Inc.'s program director and treatment therapist _____to disclose mental health information and records obtained in the course of the Chances for Change treatment program to:

School/Employer: _____ and AMC Drug Screening.

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time, unless Stay Designated, Inc. staff has taken action in reliance upon it. I also understand that such revocation must be in writing and received by Stay Designated, Inc. staff at Stay Designated, Inc.'s address to be effective.

The disclosure of information and records authorized by client is required for the following purpose: confirmation of program enrollment, completion, or incompletion.

Such disclosure shall be limited to the following specific types of information: dates and times of client's program enrollment, completion, or incompletion, and drug screening results.

Stay Designated, Inc. shall not condition treatment upon client signing this authorization. Client has the right to refuse to sign this form. Client understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Rule, although such information may be protected by applicable California Law.

This authorization shall remain valid until: _____

A copy of this original signed authorization shall be as effective and valid as the original.

Client/Guardian Signature: _____ Date: _____