



RECORDS REQUEST

ISNAP Participant Information:

Name: _____ DOB: _____

Address: _____

City, State, Zip: _____

Phone#: _____ Cell#: _____ Fax#: _____

INFORMATION TO BE RELEASED (Please "X" all items to be released)

A Positive ID must be provided by the nurse before items may be released

- | | |
|--|---|
| <input type="checkbox"/> Self-Reports | <input type="checkbox"/> AA/NA and NSG Meeting Logs |
| <input type="checkbox"/> Recovery Monitoring Agreement | <input type="checkbox"/> Addendums |
| <input type="checkbox"/> Quarterly Compliance Reports | <input type="checkbox"/> Correspondence |
| <input type="checkbox"/> UDS Results | Dates Requested: _____ |

Signed consents must be provided before items may be released

- | | |
|--|---|
| <input type="checkbox"/> Sponsor Reports | <input type="checkbox"/> Work Site Monitor(s) Reports |
|--|---|

These items must come from the original source; they cannot be released by ISNAP.

- | | |
|---|--|
| <input checked="" type="checkbox"/> Therapist Quarterly Reports | <input checked="" type="checkbox"/> Addictionist Quarterly Reports |
| <input checked="" type="checkbox"/> Assessments | <input checked="" type="checkbox"/> Discharge Summaries |

These items are the private records of ISNAP and must be subpoenaed.

- | | |
|--|--|
| <input checked="" type="checkbox"/> Intake Information | <input checked="" type="checkbox"/> Progress Notes |
|--|--|

↑ PARTICIPANT'S SIGNATURE ↓

↑ Date Signed ↓

CONFIDENTIALITY NOTICE:

Any record in ISNAP's possession that is labeled "confidential" will NOT be released to anyone. You will have to get those records from the provider.

This is NOT a 'standing' release.

If the information is to be released monthly a new release form will need to be completed every month.

Please allow up to 14 days after receipt of request to have the information released.

A fee will be charged for any requests over 10 pages.