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Director

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### Separate ATR Program Enrollment Release

*This form must be filled out by individuals who reside in Iowa and meet criteria to receive Access to Recovery (ATR) services from Great Plains Tribal Chairmen’s Health Board (GPTCHB-ATR) and the Iowa Department of Public Health (IA-ATR).*

By signing below, I acknowledge that I have requested to become a client of (check one):

- GPTCHB-ATR
- IA-ATR

I understand the following:

- I can select the ATR program that is right for me.
- I can get services from either ATR program but cannot get services from both programs.
- Receiving services from both programs could result in termination of my ATR services.

I hereby give permission for identifying demographic information to be shared between GPTCHB-ATR and IA-ATR to monitor adherence to the requirement that individuals may be involved in one ATR program only.

*I further understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 C.F.R. Pts. 160 & 164. Federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted in writing. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.*

\_\_\_\_\_  
Name (Printed)

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Parent/Guardian Signature (if applicable)

\_\_\_\_\_  
Date