YAVAPAI-APACHE NATION

Alcohol and Substance Abuse Program

Phone: (928) 649-7146 Fax: (928) 567-6485

FACT SHEET

Name: ______________________ **Date:** __________

Address: ______________________________________

City: __________ **State:** __________ **Zip code:** __________

Home Phone: __________ **Work:** __________ **Cell:** __________

Email Address: ______________________________________

SSN: ______________ **DOB:** __________ **Age:** __________

Place of Birth: ______________________ **Gender:** ______

Weight: ____________ **Height:** ________

Tribe: ____________ **Where Enrolled:** __________ **Degree:** ________

Copy of CIB or Tribal ID? ☐ **Yes** ☐ **No**

Veteran? ☐ **Yes** ☐ **No**

Fluent in any language other than English? ☐ **Yes** ☐ **No** __________

Emergency Contact Name: ______________________________

Phone: ____________ **Address:** ______________________

Employer Name: ______________ **Address:** ______________

Phone: ____________ **Position:** ____________ ☐ **F/T or** ☐ **P/T**

Mailing Address: 2400 West Datsi – Camp Verde, Arizona 86322
Physical Address: 3462 Smith Ave – Camp Verde, Arizona 86322

Medical Ins. / Plan: ____________________ **Policy #:** _________________

Copy of Insurance Card? ☐ **Yes** ☐ **No**

Medical/Mental Health Issues? ☐**Yes** ☐**No** **If yes, explain:**

____

Current Medications: ____

Drug/Substance of Choice: ____

Date of last drink: _____________ **Date of last drug use:** __________

Date of last arrest: _____________ **Incident:** __________________________

Drugs/alcohol involved? ☐ **Yes** ☐ **No**

Who referred you to ASAP? ____

Additional agencies involved? _______________________________________

Probation/Parole Officer: ____

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CONSENT TO TREATMENT

Confidentiality of Patient Records

The confidentiality of Patient Records is maintained by the Alcohol/drug Abuse Program and protected by Federal Law and Regulations. The program may not disclose any information identifying a patient as an alcohol or drug abuser, unless:

1. The patient consents in writing
2. The disclosure is allowed by a court order, or,
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for reach, audit, or program evaluation.

Violation of the Federal Law and Regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal Regulations.

Federal Law and Regulations do not protect any information about suspected child abuse and neglect from being reported under State Law to appropriate State or Local Authorities. (e.g. C290dd-3 and 42 USC 290ee-3 for Federal Laws and 42 CFR Part 2 for Federal Regulations.)

PATIENT ACCESS AND RESTRICTIONS ON USE

a. Patient access is not prohibited. These regulations do not prohibit a program from giving a patient access to his/her own records, including the opportunity to inspect and copy any records that the program maintains consent or other authorization under these regulations in order to provide such access to the patient.
b. Restrictions on use of information. Information obtained by patient access to his/her records is subject to the restriction on use of this information in initiate or substantiate any criminal charges against the patient or to conduct any criminal investigations of the patient as provided for under 212 (d) (1).

I, ________________________________, have read, understand, and received a copy of this Confidentiality Statement. If I need further explanation, I will ask my counselor.

Client Signature	Date
Parent/Guardian Signature	Date
Witness Signature	Date

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CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I, ______________________________, AUTHORIZE YAVAPAI-APACHE ALCOHOL AND SUBSTANCE ABUSE PROGRAM TO RECEIVE AND RELEASE THE FOLLOWING INFORMATION:

a. Clinical Information, including evaluation results, diagnosis, and recommendations.
b. Attendance, drug and alcohol urinalysis, hair follicle, and / or saliva test results.
c. Progress Reports.
d. Discharge Summaries and Aftercare Recommendations.
e. Psychological, Psychiatric, and Medical Reports.
f. Other (Parole, Probation, CPS, etc.): ______________________________

SSN: ______________________________
DOB: ______________________________

TO:

Agency ______________________________

Address/Phone/Fax ______________________________

Point of Contact ______________________________

The purpose of this disclosure is to exchange information between one or more agencies/parties to assist with client's evaluation / treatment.

I understand I may revoke this consent for Release of Information at any time. However, I understand that any release made prior to my revocation of this signed authorization shall not constitute a breach of confidentiality.

______________________________ ______________
Client Signature Date

______________________________ ______________
Legal Guardian/Authorized Representative Date

______________________________ ______________
Witness Date

Consent Expires One (1) year from Original Date Signed ______________________________

Mail: 2400 West Datsi Street, Camp Verde Arizona 86322
Physical Address: 3462 Smith Avenue, Camp Verde Arizona 86322

YAVAPAI-APACHE NATION

ENROLLMENT DEPARTMENT

2400 WEST DATSI STREET, CAMP VERDE, ARIZONA 86322
PHONE: (928)567-1028 OR (928)567-1008 FAX: (928)567-1047

CONSENT TO RELEASE OF INFORMATION

____

NAME   DATE OF BIRTH

I hereby authorize the YAVAPAI-APACHE NATION ENROLLMENT DEPARTMENT to release the following information/documentation:

☐ CERTIFIED DEGREE OF INDIAN BLOOD (CIB)

☐ VERIFICATION OF MEMBERSHIP (MEMBER STATUS ONLY)

☐ COPY OF BIRTH CERTIFICATE

☐ COPY OF SOCIAL SECURITY CARD

☐ OTHER (FINANCIAL INFORMATION, ETC) ______________________________

PLEASE CHOOSE ONLY THE INFORMATION/DOCUMENTS THAT IS REQUIRED

This information is to be released to:

____

Name of Person/Department/Organization

____

Address

____

Phone

The purpose or need for this information:

____

____

____

Signature of Tribal Member (Parent/Guardian for minor)   Date