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**Alumni Consent Form**

We want to keep connected with you. Please take a moment to answer the following questions. Your answers will help in planning alumni events and services. Thank you.

ROSECRANCE INC. ALUMNI AUTHORIZATION AND CONSENT FOR DISLOSURE FOR PURPOSES OF PARTICIPATING IN THE ALUMNI PROGRAM

Rosecrance Inc. offers alumni services and activities to support former clients of Rosecrance and their family members (“Alumni”). Under Federal confidentiality and privacy rules (the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR Parts 160 and 161) – Rosecrance employees cannot disclose your personally identifiable health information (including that you or your family member were treated at Rosecrance) to offer you alumni services without your written authorization.

The purpose of this authorization is to permit Rosecrance to contact you for the purpose of participating in these activities after you finish treatment. By initialing the items below, you authorize Rosecrance to use or disclose your Contact Information as described below to provide the following alumni services:

I agree to the following:

\_\_\_\_\_\_ (Initial) Receive communications from Rosecrance and Rosecrance Alumni Program. **I understand that if I provide an email address or phone number accessible by other parties (such as a work email address viewable by employer, phone number accessed by family member, etc.), it may be disclosed that I am involved with the Rosecrance Alumni Program.**

Please check and provide information only if you would like to receive communication in this manner (check all that apply):

🔾 Telephone Calls

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🔾 Text

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🔾 E-mail

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🔾 Mail

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like to receive the monthly newsletter? Please check how you would like it delivered

**(Check One Only)** Email \_\_\_\_\_\_\_\_ Mail \_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_ (Initial) Provide my name, address, telephone number(s), and email address that I have checked above to Rosecrance staff and Alumni Program Participants who will act as a recovery resource for me.

\_\_\_\_\_\_ (Initial) Identify me as an Alumni Contact, willing to serve as a recovery resource to other alumni,

by providing my name, telephone number(s), email address, city and state to newly discharged or other alumni in need of support.

The information shall become effective immediately and shall remain in effect for five years from the date of signature.

You may revoke your authorization at any time except to the extent that action has been taken in reliance on this authorization prior to revocation. To revoke this consent, your revocation must be in writing and sent to the attention of Alumni Coordinator, 1601 University Dr., Rockford, IL, 61107. If you have any questions, you may contact the Alumni Program Coordinator at 815-391-1000.

The information disclosed in connection with these alumni services has also been disclosed from records protected by Federal Regulations concerning the Confidentiality of Alcohol and Drug Abuse Records (42 CFR Part 2) and State Law protecting confidentiality of patient records. These laws prohibit making further disclosure unless as is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

You understand that you must observe these confidentiality restrictions for other alumni participating in these activities. You have the right to inspect or copy your information that is used or disclosed in accordance with this authorization. You have a right to request restrictions on the use or disclosure of your personally identifiable health information. While this authorization is required as a condition to Rosecrance offering you alumni support services, it is not required as a condition of providing you treatment, of accepting payment, or of your eligibility for benefits. You may refuse to sign this authorization, but such refusal will prohibit your participation in future Rosecrance Alumni Program services as outlined above. You may request a copy of your consent be mailed to your address.

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Alumni Name (Printed) Alumni Signature Date

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Parent/ Guardian Name (Printed) Parent/ Guardian Signature Date

*\*if applicable*

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Witness Name (Printed) Witness Signature Date

***Please return the completed form to Alumni Coordinator, 1601 University Dr., Rockford, Illinois 61107***

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