



ACCESS TO
RECOVERY



California Access to Recovery Effort (CARE) Program Outline for Client Success Stories and Provider Profiles

Client Success Story

Elements of success stories usually include:

- Person's name, age, and hometown.
- Family/children.
- What led them to start using alcohol or other drugs?
- How did drug abuse/addiction impact their life?
- What led to them to get help?
- How is their life better today because of CARE's clinical treatment and/or recovery support services?

The Provider

(Provider name) has been working at (program name) for (years). He/she chose a career in prevention/treatment because_____.

(Provider name) feels they are successful with (type of clients or participants) because_____. How has (provider name) been able to better serve clients since they joined the CARE network?

Photos/Authorization Forms

Print or digital photos of providers/participants are very much encouraged but not required. Digital photos must be 260 - 300 dpi, **preferably close-ups of people**. Print photos will be returned if requested. Signed authorizations are required for all photos submitted. The authorization form is below.



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AUTHORIZATION TO RELEASE INFORMATION AND PHOTOGRAPHS

Authorization for publishing information about :				
NAME	LAST	FIRST	MIDDLE	DOB:
Mailing Address: _____				
Email Address: _____				
Release information to:				
ORGANIZATION OR AFFILIATION California Department of Alcohol and Drug Programs				
TELEPHONE NUMBER (INCLUDE AREA CODE) (916) 445-0323		FAX NUMBER (INCLUDE AREA CODE) (916) 445-0846		E-MAIL ADDRESS sheavens@adp.ca.gov
ADDRESS 1700 K Street		CITY Sacramento	STATE CA	ZIP CODE 95814
REASON FOR RELEASE To provide information and/or photographs for publications developed by the Department of Alcohol and Drug Programs and/or its partners and funding sources, to promote education about the CARE Program's effectiveness in servicing individuals recovering from addiction.				
Authorization for release:				
<p>I authorize the California Department of Alcohol and Drug Programs (ADP), and the following agencies if applicable, to release information about my /my child's participation in CARE for publishing by the Department of Alcohol and Drug Programs. I also authorize the use of my/my child's photograph. I understand that information may be provided verbally or by computer data transfer, mail, fax, or hand delivery to:</p> <ul style="list-style-type: none"> • MAXIMUS, an ADP contractor for the CARE Program; and/or • The federal Substance Abuse and Mental Health Services Administration, the CARE grant funder. <p>I understand and agree to the release of information authorized in this form. I understand I may revoke this release in writing at any time, but I understand that revocation will not affect any information that was already released. A copy of this form is valid to give my permission to release records.</p>				
AUTHORIZED BY (SIGNATURE)		DATE SIGNED	TELEPHONE NUMBER (INCLUDE AREA CODE)	
PRINT NAME				
<p>If I am not the person whose information is being released, I am authorized to sign because I am the:</p> <p><input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian (attach court order) <input type="checkbox"/> Other:</p>				

To those receiving information under this authorization: Federal and state laws and regulations protect the information disclosed to you. You may not release it to any other person or entity without specific written consent. You are subject to the same standards and laws of confidentiality as the originating holder of the records.