



# California Access to Recovery Effort

(CARE)

Revised 12\_08

## CUSTOMER SATISFACTION SURVEY CONSENT FORM

I \_\_\_\_\_ authorize \_\_\_\_\_  
(Client name) (Provider name)

to disclose to the California Department of Alcohol and Drug Programs (ADP) my name, telephone number and mailing address.

**The purpose of the disclosure is for ADP to contact me either by telephone or mail after I have completed the CARE voucher program to survey my satisfaction with services provided.**

I understand that my alcohol and/or drug treatment 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 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically one year after I discontinue all CARE services. I have been provided a copy of this form.

- I consented to participate in the CARE program without parental consent; OR
- My parent, guardian or custodian consented to my participation in the CARE program. (If so, the parent or guardian must sign below.)

Dated: \_\_\_\_\_  
Signature of client

I, \_\_\_\_\_, am the parent, legal guardian or custodian, appointed under California law and am authorized to act on behalf of the minor, \_\_\_\_\_. I hereby consent to this limited disclosure under the terms stated above. The parent, legal guardian or custodian is the legal representative of the unemancipated minor, pursuant to HIPAA, 45 CFR 164.502(g), unless otherwise required by law.

Dated: \_\_\_\_\_  
Signature of Parent, Guardian or Authorized Representative (when required)

Program Name: \_\_\_\_\_

Program Address: \_\_\_\_\_

CARE Provider # \_\_\_\_\_