



Greetings:

The Wellspring Residential Programs have put together this application packet to get you started with the screening and admission process. All documents need to be filled out completely and returned for Wellspring to communicate with you. You will be scheduled for an initial assessment and then discussion regarding admission and waiting list guidelines. Good communication is our goal to ensure a smooth and efficient process for individuals seeking treatment.

This packet contains the following documents:

- Residential application form (6 pages)
- The AC-OK Screening Questionnaire (1 page)
- Wellspring's Policy on Controlled Substances (medication) (1 page)
- Client Financial Responsibility including Room & Board Policy (2 pages)
- Trauma Informed Care Overview (1 page)
- Overview of Wellspring's Residential Treatment Program (3 pages)
- Connecting w/ Family and the Community (1 page)
- An Authorization to Release Information form (1 page)

Note: The Release of Information form is what will allow Wellspring to communicate with you or authorized referring organization as part of our admission process. Also, please be aware that after the screening process, additional authorization forms may be needed in order to speak with previous treatment providers, lawyers, probation officers, or other entities specific to treatment. This process will identify whether our facility is a good fit for your treatment needs.

The packet of information can be emailed to the program's Administrative Assistant, or via the US Postal Service to the address below. Please specify which program you are applying for:

**Wellspring Inc.**  
**ATTN: Men's House, Women's House, or Infinity House**  
**98 Cumberland Street**  
**Bangor, Maine 04401**

If you have any questions or need further information, please contact the programs Administrative Assistant you are applying for:

- Men's House- Jill Sanborn at 207-941-1600 ext. 401; [jsanborn@wellspringsa.org](mailto:jsanborn@wellspringsa.org)
- Women's House- Patty Rudge at 207-941-1639 ext. 301 [prudge@wellspringsa.org](mailto:prudge@wellspringsa.org)
- Infinity House- Jenna Bragdon at 207-217-6550 ext. 501 [jbragdon@wellspringsa.org](mailto:jbragdon@wellspringsa.org)

Thank you for your interest in Wellspring! We look forward to supporting you through your journey.

Respectfully,

Lisa Williams, LADC, CCS  
Clinical Director of SUD Services

**Wellspring Residential Programs  
APPLICATION FOR ADMISSION**

Rev. 10-17

**I. PERSONAL INFORMATION**

Name \_\_\_\_\_ Date \_\_\_\_\_  
Date of birth \_\_\_\_\_ Phone \_\_\_\_\_ Soc Sec # \_\_\_\_\_  
Address \_\_\_\_\_

Person to contact if you can't be reached:

name address phone  
Referral source: \_\_\_\_\_  
name/agency address phone

**II. PRESENTING PROBLEM – Why do you want to come to Wellspring?**

**III. BACKGROUND INFORMATION**

Current or Recent Living Arrangement: (prior to incarceration, if applicable)

Marital Relationship status: ☐ single ☐ married ☐ divorced ☐ separated ☐ widowed ☐ significant other

Children:

age	name	who has custody	living with whom	reason
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Is the Department of Human Services involved with your family?    yes    no

Name of caseworker/office \_\_\_\_\_

**If applying for Infinity House you must complete the Alternative Child Care Plan on Page 6**

Nature of Current Family Relationships: \_\_\_\_\_

Family Make-up When Growing Up (parents, step-parents, brothers, sisters, grandparents): \_\_\_\_\_

Relationships with Extended or Other Family Members: \_\_\_\_\_

Significant events, losses, delays, trauma/abuse (physical, emotional, sexual, verbal): \_\_\_\_\_

Education: (highest grade completed, diploma GED, history of significant problems, current activities, plans/interests)

**Employment/finances:**

If currently employed, list occupation \_\_\_\_\_

When last employed &amp; occupation \_\_\_\_\_

Source of income &amp; amount \_\_\_\_\_

Health insurance: private Blue Cross MaineCare Medicare military coverage/Togus  
other – specify \_\_\_\_\_

Are you a veteran? yes no

**Legal Status: Current**

Legal proceedings pending - what/when \_\_\_\_\_

Probation – how long \_\_\_\_\_ name of Probation Officer \_\_\_\_\_

Parole &amp; Parole Officer: \_\_\_\_\_

Drug court – where \_\_\_\_\_

Attorney's name/phone \_\_\_\_\_

**Legal History:** Number of arrests \_\_\_\_\_ Charges \_\_\_\_\_

Convictions: number of OUIs \_\_\_\_\_ number/types felonies \_\_\_\_\_

Recreation (hobbies, interests, things you like to do) \_\_\_\_\_

Spirituality/religion: \_\_\_\_\_

Social support (friends, neighbors, churches, agencies) \_\_\_\_\_

**IV. HEALTH INFORMATION**

Current health status: excellent good fair poor

Describe current health (incl sleep, appetite, limitations/spec needs, illness, nutrition – adequate inadequate): \_\_\_\_\_

Have you been tested for HIV? If so, when, where \_\_\_\_\_ HIV testing offered \_\_\_\_\_

Have you been tested for Hep C? If positive, when/status: \_\_\_\_\_

Pregnant: ☐ yes ☐ no If yes, how long? \_\_\_\_\_ Receiving pre-natal care? \_\_\_\_\_

Significant health history (health problems, surgery, injuries, head trauma, etc): \_\_\_\_\_

Current tobacco use: \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, amount \_\_\_\_\_ Interested in quitting? \_\_\_\_\_

Caffeine use: \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, amount \_\_\_\_\_ Interested in quitting? \_\_\_\_\_

Last physical: \_\_\_\_\_ Current primary care provider: \_\_\_\_\_

Allergies (food, meds, other): \_\_\_\_\_

Limitations or special needs: walking stairs chores lifting hearing vision none

Explain \_\_\_\_\_

**Current Medications (Medical and Mental Health/Prescribed and over-the-counter):****I have read and agreed to Wellspring's medication prescribing policy:**☐ Yes☐ No

name

reason for taking

amount

how often

since when

**V.SUBSTANCE ABUSE HISTORY**

Drug (List all drugs – be specific)	Check your top 3 drugs of choice (1, 2, 3)	Age when use became regular	Used drugs IV?	How much did you usually use?	How often did you use?	When did you last use?
Alcohol						
Amphetamines						
cocaine/crack						
hallucinogens (LSD, mushrooms, PCP)						
Heroin						
inhalants (specify)						
Marijuana						
narcotics/opiates other than heroin						
sedatives/benzodiazapines (Xanax, Klonopin, etc)						
bath salts						
steroids (muscle enhancers)						
other (specify)						

**Problems from AOD use (check):****Physical**

trauma/accidents      loss of consciousness  
 health                  tremors  
 blackout                hangovers  
 DTs                        vomiting  
 overdose                tolerance  
 hallucination            loss of control

**Psychological**

mood fluctuations  
 depression  
 anxiety  
 anger/rage  
 paranoia  
 personality changes

**Social**

relationships  
 school  
 job  
 legal  
 financial  
 fights/quarrels

Comment on the three things that bother you most: \_\_\_\_\_

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**Previous Substance Use Disorder Treatment:**Describe any recent (within the last 2 years) any Detox experiences (Alcohol, Opiates, Benzos, Meth, Bath Salts, etc.):  

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**Outpatient Substance Use Disorder Treatment (Counseling, IOP, Methadone, Suboxone, DEEP etc.):****Type of Treatment & Where****When****Length of Stay****Sobriety After**  

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**Residential Substance Use Disorder Treatment (Wellspring, Cross Roads, Serenity House, St. Francis, Maine Gen., etc.)****Where****When****Length of Stay****Sobriety After**  

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Any Period(s) of Abstinence? ☐ no ☐ yes If yes:**When/Length****Quality of Life****What Helped or Motivated**

Latest period of abstinence \_\_\_\_\_

Longest period of abstinence \_\_\_\_\_

Self-help group experience (type, when, length of involvement, participation): \_\_\_\_\_  
\_\_\_\_\_Reasons for/circumstances of relapse: \_\_\_\_\_  
\_\_\_\_\_Other compulsive/excessive behaviors – circle and describe (laxatives, sex, eating, spending, shoplifting, Internet, etc):  
\_\_\_\_\_

If you gamble or play scratch tickets, have you ever felt the need to bet more and more? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you ever had to lie to people important to you about how much you gambled? Yes \_\_\_\_\_ No \_\_\_\_\_

Family history of substance abuse: \_\_\_\_\_  
\_\_\_\_\_**VI. MENTAL HEALTH HISTORY****Current problems:** Have you been given a mental health diagnosis? yes no don't knowDo you know what it is? Please describe: \_\_\_\_\_  
\_\_\_\_\_**Psychiatric/Mental Health Hospitalizations (Acadia Hosp., Spring Harbor, Dorothea Dix, Riverview, AMHI, Mid-Coast, St Mary)****Where****When****For how long****Reason/Problem**  

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**Residential Mental Health Treatment (Morrison Place, Maine Stay, The Bridge, Sweetser, etc.):****Where****When****For how long****Reason/Problem**  

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**Outpatient Psychiatry & Mental Health Treatment (McGeachey Hall, CHCS, Acadia Hosp., Maine Med., St. Mary, etc.)**

Where	When	For how long	Reason/Problem

Are you a member of the Consent Decree? \_\_\_\_\_

Have you attempted suicide: no yes How many times \_\_\_\_\_ last time \_\_\_\_\_ how \_\_\_\_\_  
Consequences \_\_\_\_\_

Have you engaged in self-harm: cutting burning hitting self other \_\_\_\_\_  
when \_\_\_\_\_ how often \_\_\_\_\_ last time \_\_\_\_\_

Have you been a victim of: domestic violence physical abuse sexual assault

Have you been charged with: domestic violence physical abuse sexual assault

Do you have a family history of mental health problems? If so, who and what? \_\_\_\_\_

**Current or recent mental health symptoms of concern (check, circle, and describe):**

Depression (sadness, low self-esteem, lack of interest/pleasure): \_\_\_\_\_

Anxiety (worry, fear, panic): \_\_\_\_\_

Anger (irritability, outbursts, reactivity): \_\_\_\_\_

Sleep (falling asleep, awakening, nightmares, excessive): \_\_\_\_\_

Cognitive (poor attention, memory problem): \_\_\_\_\_

Disturbing thoughts/memories: \_\_\_\_\_

Restlessness, fidgeting: \_\_\_\_\_

Hallucinations (hearing/seeing things others don't): \_\_\_\_\_

Other: \_\_\_\_\_

**Does your drug use make these symptoms worse or better? Please explain:**

**If you have had periods of sobriety or abstinence, were these symptoms worse or better? Please explain**

**Alternative Child Care Plan:** (For those applying for Infinity House)

Who should program staff contact in the event you are unable to provide care to your child (i.e., hospitalization, discharge from program, etc.):

<b><u>Name:</u></b>	<b><u>Relation:</u></b>	<b><u>Telephone #</u></b>

**Please note:** you must sign a release of information for individuals listed on your alternative care plan upon admittance to the program and are responsible for updating this plan with staff immediately with changes.

**VII. AC-OK SCREENING QUESTIONNAIRE****PLEASE ANSWER THE FOLLOWING QUESTIONS BY CIRCLING YES OR NO****During the past year:**

- |   |     |    |
|---|-----|----|
| 1. Have you been preoccupied with drinking alcohol and/or using other drugs?  | Yes | No |
| 2. Have you experienced problems caused by drinking alcohol and/or using other drugs, and you kept using?   | Yes | No |
| 3. Do you, at times, drink alcohol and/or used other drugs more than you intended?  | Yes | No |
| 4. Have you needed to drink more alcohol and/or use more drugs to get the same effect you used to get with less?  | Yes | No |
| 5. Do you, at times, drink alcohol and/or used other drugs to alter the way you feel?   | Yes | No |
| 6. Have you tried to stop drinking alcohol and/or using other drugs, but couldn't?  | Yes | No |
| <hr/>   |     |    |
| 7. Have you experienced serious depression (felt sadness, hopelessness, loss of interest, change of appetite or sleep pattern, difficulty going about your daily activities)? | Yes | No |
| 8. Have you experienced thoughts of harming yourself?   | Yes | No |
| 9. Have you experienced a period of time when your thinking speeds up and you have trouble keeping up with your thoughts?   | Yes | No |
| 10. Have you attempted suicide?   | Yes | No |
| 11. Have you had periods of time where you felt that you could not trust family or friends.   | Yes | No |
| 12. Have you been prescribed medication for any psychological or emotional problem?   | Yes | No |
| 13. Have you experienced hallucinations (heard or seen things others do not hear or see)?   | Yes | No |
| <hr/>   |     |    |
| 14. Have you ever been hit, slapped, kicked, emotionally or sexually hurt, or threatened by someone?  | Yes | No |
| 15. Have you experienced a traumatic event and since had repeated nightmares/dreams and/or anxiety which interferes with you leading a normal life?                           | Yes | No |

Counselor Reviewed - Signature

MH	SA	T

**SIGNATURE OF APPLICANT:**

Print Your Name

Signature

Date





## Wellspring, Inc. Controlled Substances Guidelines

Wellspring is committed to providing a safe, supportive, and clinically appropriate environment for substance use and co-occurring mental health treatment. As part of this commitment, we maintain policies regarding prescribed controlled substances, including but not limited to:

- Benzodiazepines (e.g., Xanax, Klonopin, Ativan)
- Stimulants (e.g., Adderall, Ritalin)
- Opioid medications (e.g., oxycodone, hydrocodone)
- Sedative-hypnotics or barbiturates
- Other DEA Schedule II–V medications, or other prescribed medications

**Please be advised as you apply for admission, these medications may or may not be continued while you are a resident at Wellspring.** Due to the potential interference with therapeutic progress, and your recovery, Wellspring asks you to work with your prescriber to ensure a therapeutic dose that allows for active engagement in your treatment.

Wellspring is committed to working collaboratively with outside prescribing providers to support safe and clinically appropriate care, including advocating for medications for opioid use disorder. Our clinical staff will coordinate with your current prescribers to assess medication needs, explore alternative and supportive treatments when appropriate, and ensure continuity of care that aligns with the goals of recovery and program safety.

By signing below, I acknowledge that:

- I have been informed that Wellspring may not be able to continue or advocate for the use of controlled substances without further review.
- I understand that Wellspring will make reasonable efforts to communicate and coordinate care with my outside prescribing provider(s) to determine the best course of action for my treatment and safety.
- I agree to fully disclose all current medications and prescribing providers during the intake and assessment process.
- I authorize the release and exchange of medical and medication-related information between Wellspring and my outside providers for the purpose of care coordination.
- I understand that if my current medication regimen is determined to be clinically inappropriate or unsafe in a residential treatment setting, adjustments may be recommended, including tapering or transitioning to non-controlled alternatives.
- I understand that undisclosed medication use, misuse, or diversion may affect my eligibility for continued treatment in the program.

If I have questions about this policy or its implications for my treatment, I have been given the opportunity to discuss them with program staff.

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Client Signature

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Date



## NOTICE of Financial Responsibility for treatment at Wellspring's Residential programs

1. I understand that I am financially responsible for any medical and doctor's fees incurred during admissions and treatment. This includes the initial physical exam that happens during the first (5) days of admissions and for all prescription medications purchased while I am a resident at one of Wellspring's Residential Programs (Men's House, Women's House or Infinity House). If I am unable to pay for the medication when it is purchased, I will reimburse Wellspring before I leave the program.

2. I understand that if I am eligible for the *Supplemental Nutrition Assistance Program*, (SNAP) also known as *Food Stamps*, I will submit my SNAP EBT card to Wellspring to use toward my meals while in the treatment program. Upon leaving the treatment program, Wellspring will return my card to me.

NOTE: If I leave the program after the 16<sup>th</sup> day of the month, I understand that Wellspring will have used all of the monthly allocation amounts on my SNAP benefit allocation EBT card (excluding the amount on the card that you came into the program with at admission). If I leave before the 16<sup>th</sup> of the month, I will receive my full monthly allocation when my card is returned to me.

### Example A:

March 31: Arrival and the EBT card has a balance of:	\$35.00
April 1 <sup>st</sup> : Monthly SNAP allocation added to card:	\$65.00
April 16 <sup>th</sup> : Wellspring draws down monthly allocation:	<u>\$-65.00</u>
April 17 <sup>th</sup> : Client leaves program, SNAP card balance is:	\$35.00

### Example B:

March 31: Arrival and the EBT card has a balance of:	\$35.00
April 1 <sup>st</sup> : Monthly SNAP allocation added to card:	<u>\$65.00</u>
April 10 <sup>th</sup> : Client leaves program, SNAP card Balance is:	\$100.00

NEXT ➡



3. I understand that I am responsible for the Room and Board Fee for which I will be billed for on a per-day basis.

NOTE: This is calculated on a sliding scale based on your income and it ranges between \$1.00/day to \$10.00/day. The amount you are responsible for will be assessed during the admissions process and a determination of your fiscal responsibility will be discussed then.

NOTE: Mainecare only covers the treatment portion of your stay. Mainecare **DOES NOT** pay for the cost of room and board.

I understand the information outlined in this document regarding my financial responsibilities while I am in treatment in the Wellspring Residential programs.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Trauma Informed Care

Trauma Informed Care (TIC) recognizes that traumatic experiences **terrify, overwhelm and violate** the individual. TIC is a commitment not to repeat these experiences and, in whatever way possible, to **restore a sense of safety, power and worth**.

## The Foundations of Trauma Informed Care

Commitment to Trauma Awareness

Understanding the Impact of  
Historical Trauma and Oppression

Agencies Demonstrate Trauma Informed Care with Policies, Procedures and Practices that:

### Create Safe Context through:

- Physical safety
- Trustworthiness
- Clear and consistent boundaries
- Transparency
- Predictability
- Choice

### Restore Power through:

- Choice
- Empowerment
- Strengths perspective
- Skill building

### Build Self-Worth through:

- Relationship
- Respect
- Compassion
- Acceptance and Nonjudgment
- Mutuality
- Collaboration



## Overview of Wellspring's Residential Treatment Program for *Substance Use Disorder (SUD)*.

The residential treatment programs at Wellspring are designed to provide trauma-informed treatment for people with a history of chronic substance use disorder; including those with co-occurring mental health disorders. The programs are long term - ranging from 4-months to 6-months and focus on supporting and guiding individuals toward gaining sobriety, maintaining sobriety and building the skills needed for independent living. This includes *building strong connections with the recovery community*.

**NOTE: Community Supports are considered vital to successful recovery.** Building connections with the Recovery Community is something that will be there for you long after you leave the highly structured residential treatment program.

To be considered for admission to our treatment in one of our residential programs, you must be:

- Eighteen Years of age or older
- Free of mood-altering substances on the day of admission
- Physically and mentally able to participate in a therapeutic community environment.
- Motivated for treatment.

At each of Wellspring's residential treatment programs we use a combination of treatment modalities along with medication management and daily living education to support overall rehabilitation.

The following trauma-informed services are offered while in residence:

- Individual, family and group SUD counseling sessions
- Educational and vocational counseling



- Specialized treatment and psychiatric consultation for residents with co-occurring mental health disorder needs.
- Referrals to community support services
- Participation in the Greater Bangor area 12-step community
- Support and education for managing daily living skills

Group Psycho-education topics include:

- Addiction and Recovery
- Relapse Prevention Skills
- Insight processing
- Community Issues
- Family Roles
- Gender specific

Daily Living Skill activities include:

- Completion of scheduled household chores including meal preparation and, cleaning, vacuuming, and mopping floors, etc.
- Maintaining bedrooms in a clear and orderly fashion including beds made daily.
- Personal laundry
- Daily personal hygiene
- Learning time management skills in order to keep up with daily treatment assignments, appointments, chores and other program requirements.

These activities are designed to lend themselves to the development of relapse prevention skills that will go with the client upon graduation of the program and as they transition to independent living.

Our programs also offer daily meditations and house meetings. Participants are expected to actively take part in 12-step support or other types of support groups



offered in the community in order to build a personalized recovery network that will aid in their recovery, post treatment.



Q & A:

**1. *Will I still get to see my family and children?***

-Absolutely. We encourage everyone to take responsibility for their children and to maintain close contact with their family.

**2. *How much contact will I have with the outside world?***

-Recovery is much more than maintaining sobriety. Recovery involves setting goals that will foster a life that allows you to have independence, family connections and supports, self-confidence and a new lifestyle that will lead to success in many areas of life.



## Connecting with Family and the Community while in Residential Treatment

We believe that it is important for people in recovery to maintain close relationships with their children and positive family supports.

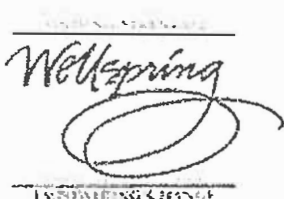
We encourage scheduled visits from spouses and other family members, as long as they are free of mind-altering substances when visiting and also that they do not present any safety issues. All visitors must comply with program rules and regulations.

It is part of the treatment philosophy at Wellspring that residents have opportunities to practice their recovery skills in the community. Examples include the issuance of weekend passes (when eligible and treatment appropriate); as well as obtaining employment and /or continued education. (Residents are encouraged to seek and obtain volunteering opportunities or employment during their latter phases of treatment.)

Additionally, residents are exposed to and meet w/ a variety of community resources such as:

- The Bangor Area Recovery Network (aka *the* BARN)
- Spruce Run for survivors of domestic violence
- Courage Lives: Consortium of services for survivors of human trafficking.
- The Learning Center
- The Career Center





## Authorization to Release/Receive Information

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

DOB: \_\_\_\_\_ Date: \_\_\_\_\_

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 1966 (HIPAA), 45 C.F.R. Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. These rules prohibit the recipient of confidential information from further disclosure of it unless that disclosure is expressly permitted by your written consent or as otherwise permitted by 42 C.F.R. Part 2. I understand that generally Wellspring may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I understand that I may request a list of records disclosed to whom, when, and for what purpose at any time during or after treatment. I will be given a copy of this form if I request it.

I, \_\_\_\_\_, authorize Wellspring and  
\_\_\_\_\_  
(name, agency, address, phone)

to communicate with and disclose to one another the following information:

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Admission status      | <input type="checkbox"/> Biopsychosocial History                   | <input type="checkbox"/> Medical Consultation  | <input type="checkbox"/> Aftercare Plan    |
| <input type="checkbox"/> Presence in Treatment | <input type="checkbox"/> Clinical Assessment                       | <input type="checkbox"/> Treatment Plan        | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Admission Summary     | <input checked="" type="checkbox"/> Psychological/Psychiatric Eval | <input type="checkbox"/> Progress in treatment | <input type="checkbox"/> Recommendations   |
| <input type="checkbox"/> Other _____           |  |  |  |

The purpose of this disclosure is to:

- |   |   |
|---|---|
| <input type="checkbox"/> Schedule appointments                | <input type="checkbox"/> Plan or coordinate treatment and services              |
| <input type="checkbox"/> Facilitate meeting legal obligations | <input type="checkbox"/> Obtain/maintain employment, government, other benefits |
| <input type="checkbox"/> Other _____                          |   |

I understand that I may revoke this consent in writing at any time, except to the extent that action has been taken on it. Unless revoked, this consent will automatically expire one year from the date signed, unless otherwise specified below:

\_\_\_\_\_  
(Specify date, event, or condition to expire)

*PCHC and CFM are contracted providers for Wellspring. Wellspring will not release documentation for services provided by these agencies for Wellspring clients. To obtain a copy of those records, please submit your request for records directly. Penobscot Community Health Centers, Medical Records, Union Street, Bangor, ME 04401 TEL 207-404-8200. Northern Light Family Medicine and Residency, 895 Union St, Bangor, ME 04401. TEL 207-973-7979.*

- |                               |                                 |   |
|-------------------------------|---------------------------------|---|
| I <input type="checkbox"/> do | <input type="checkbox"/> do not | authorize information to be faxed. I understand that there are confidentiality risks in fax transmissions.  |
| I <input type="checkbox"/> do | <input type="checkbox"/> do not | authorize disclosure of information that refers to treatment or diagnosis of drug or alcohol abuse.   |
| I <input type="checkbox"/> do | <input type="checkbox"/> do not | authorize disclosure of information that refers to treatment or diagnosis of psychiatric illness.   |
| I <input type="checkbox"/> do | <input type="checkbox"/> do not | authorize disclosure of information that refers to treatment or diagnosis of HIV, ARC or AIDS.  |
| I <input type="checkbox"/> do | <input type="checkbox"/> do not | authorize redisclosure of this information to _____   |
| I <input type="checkbox"/> do | <input type="checkbox"/> do not | wish to review my Wellspring records before their release. If I do, a program director or designee will supervise my review and document the supervision below. |

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

Parent/Guardian \_\_\_\_\_ Relationship \_\_\_\_\_

To be valid, all sections above must be completed.

Revocation: ☐ by phone ☐ in person ☐ other \_\_\_\_\_ Date \_\_\_\_\_ Date written confirmation rec'd \_\_\_\_\_

(Revised 10/24)