NEW SEASON

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient ID: _____
Date: _____

I, _____, _____,
Name of Patient *Date of Birth*

authorize _____
Name or general designation of organization/person making/requesting disclosure.

_____
Address of treatment center from which records are being requested.

to disclose to/receive from: _____
Name of organization and/or person to/from which disclosure is to be made/requested.

the following information:

_____,
Nature of the information, as limited as possible.

including:

❒Intake Paperwork	❒Toxicology/Drug Test Results
❒Billing Records	❒Psychosocial Evaluation or Assessment
❒Discharge/Transfer Summary	❒MAR (Medication Administration Record)
❒History & Physical	❒Prescription Verification/COC
❒Treatment Plan/Review	❒Medical Test Results
❒Other:	

The Purpose of the disclosure authorized herein is to:

Purpose of disclosure, as specific as possible.

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality 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 by 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 this consent expires automatically in 12 months from the date signed, unless I specify an expiration event, date or condition here:

_____
Specific date, event, or condition upon which this consent expires; should not be longer than reasonably necessary to serve the purpose of the disclosure.

I understand that I may be denied services if I refuse to consent to disclosure for purposes of treatment, payment, or healthcare operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I understand that if my record contains information from other providers relating to substance use disorder treatment, such information will only be released with my written authorization for the disclosure of this provider's records and the re-disclosure of the other provider's records.

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient ID: _____
Date: _____

THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS PROTECTED BY FEDERAL CONFIDENTIALITY RULES (42 CFR PART 2). THE FEDERAL RULES PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF INFORMATION IN THIS RECORD THAT IDENTIFIES A PATIENT AS HAVING OR HAVING HAD A SUBSTANCE USE DISORDER EITHER DIRECTLY, BY REFERENCE TO PUBLICLY AVAILABLE INFORMATION, OR THROUGH VERIFICATION OF SUCH IDENTIFICATION BY ANOTHER PERSON UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY THE WRITTEN CONSENT OF THE INDIVIDUAL WHOSE INFORMATION IS BEING DISCLOSED OR AS OTHERWISE PERMITTED BY 42 CFR PART 2. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS **NOT** SUFFICIENT FOR THIS PURPOSE (SEE SEC. 2.31). THE FEDERAL RULES RESTRICT ANY USE OF THE INFORMATION TO INVESTIGATE OR PROSECUTE WITH REGARD TO A CRIME ANY PATIENT WITH A SUBSTANCE USE DISORDER, EXCEPT AS PROVIDED AT SEC. 2.12(C)(5) AND 2.65.

I was offered a copy of the release of information, and at this time, ◯ Accept or ◯ Decline a copy.

Signature of Patient	Date
Signature of Witness	Date
Signature of parent, guardian or authorized Representative, when required	Date