|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Program A****Name****Address****Phone** **Fax** | **Program B****Name****Address****Phone** **Fax** | **Program C****Name****Address****Phone** **Fax** | **Program D****Name****Address****Phone** **Fax** | **Program E****Name****Address****Phone** **Fax** |
| **Program F****Name****Address****Phone** **Fax** | **Program G****Name****Address****Phone** **Fax** | **Program H****Name****Address****Phone** **Fax** |  |  |

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(name), date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ request/authorize the following

(please initial all that apply):

To:\_\_\_\_\_\_\_\_\_\_\_ disclose information to and/or \_\_\_\_\_\_\_\_\_\_\_obtain information from:

|  |  |
| --- | --- |
|  \_\_\_\_\_\_\_\_**All organizations listed below OR initial all that apply below** |  |
| \_\_\_\_\_\_\_\_\_\_\_Program A | \_\_\_\_\_\_\_Program B | \_\_\_\_\_\_\_Program C | \_\_\_\_\_\_\_\_\_Program D |
| \_\_\_\_\_\_\_\_\_\_\_Program E  | \_\_\_\_\_\_\_Program F | \_\_\_\_\_\_\_\_\_\_\_Program G | \_\_\_\_\_\_\_\_Program H |

\_\_\_\_\_\_\_\_\_\_\_(initial) This release allows communication and collaboration through all facilities authorized above. I understand and allow communication between authorized facilities for **referral, care management, and continuity of care.**

\_\_\_\_\_\_\_\_\_\_\_(initial) This release allows communication and disclosure of **data to and from Actionable Data Consulting** for the purpose of analyzing the effectiveness of this collaborative project and learning how to replicate it in other places.

I authorize the release and /or disclosure of the following records (initial all that apply):

|  |
| --- |
| **Types of Information** |
| \_\_\_\_\_\_\_\_\_\_ | **All listed below OR initial all that apply below** |
| \_\_\_\_\_\_\_\_\_\_ | Name/date of birth/identifying information |
| \_\_\_\_\_\_\_\_\_\_ | Behavioral, mental, and physical health and substance use disorder related medical records, assessments and screening tool results |
| \_\_\_\_\_\_\_\_\_\_ | Progress notes, treatment plan or discharge information, attendance information |
| \_\_\_\_\_\_\_\_\_\_ | Written and/or verbal communications |
| \_\_\_\_\_\_\_\_\_\_ | Financial information |
|  |  |
| **Dates of Service** |
| \_\_\_\_\_\_\_\_\_\_ | All dates of services OR \_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_(write date range of records to be released) |

**Purpose**

\_\_\_\_\_\_\_\_\_\_ All listed below

\_\_\_\_\_\_\_\_\_\_ Further treatment/coordination of care

\_\_\_\_\_\_\_\_\_\_ At the request of the client

\_\_\_\_\_\_\_\_\_\_ Legal purposes

\_\_\_\_\_\_\_\_\_\_ Evaluation of program

\_\_\_\_\_\_\_\_\_\_ Payment/healthcare operations

\_\_\_\_\_\_\_\_\_\_ Other

**Length of time this consent for release of information is in effect**

This consent for release of information expires one year from the date it is signed or \_\_\_\_\_\_\_\_\_\_(fill in time period),

unless it is revoked as described on the last page.

\_\_\_\_\_\_\_\_\_(initial) I understand that the information in this health record may contain information relating to substance use diagnoses and/or treatment, mental health diagnosis, and/or treatment and/or Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I have the last page of this consent, have been provided with a copy of my rights and responsibilities and understand the purpose of this consent form.

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| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature of Client\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Signature of Parent/Guardian/Representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Signature of Witness | Print Name | Date |

**PLEASE SEE NEXT PAGE FOR ADDITIONAL SIGNATURE**

**Disclosure of Alcohol and Drug Treatment Information**

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 Points 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I will not be denied services or benefits if I refuse to consent to a disclosure.

The purpose of this Consent for Release of Information has been explained to me, and I understand the records that will be released, who they will be released to, and the purpose of this release, and what they will be used for. The terms and consequences of the release have been fully explained to me.

A statement of prohibition against redisclosure or protected health information will be made with any disclosures. I understand that health information covered by Federal Law 42 CFR Part 2 (Alcohol and Drug Abuse Confidentiality) is prohibited from further disclosure without my written consent. A general authorization for the release of medical information is not sufficient for this purpose and the federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug substance use disorder patient.

I understand that I may revoke a consent at any time, except to the extent that action based on this consent has already been taken. Revocations related to substance use information can be made orally, verbally, and revocations related to information not covered by substance abuse confidentiality laws must be made in writing. See an official at each organization to revoke a consent. If treatment is mandated as part of probation requirements. A consent may not be revoked until conditions of probation are met or probation ends.

I have the right to receive a copy of this signed consent form. I understand that a copy or fax of this authorization of consent is valid. I understand that upon my written request, the disclosure organization must provide a record of disclosures made for legal, administrative, or quality assurance purposes.

**NOTICE: Prohibiting redisclosure of alcohol and drug treatment information**

This information has been disclosed to you from records protected by Federal confidentiality rules (42CFR 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 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 2.12(c)(5) and 2.65.

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| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature of Client | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Print name | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date |
| STOP: ONLY sign below if you are wanting to revoke your original authorization for Release of Information dated \_\_\_\_\_\_\_\_\_\_. If you wish to change the information to be released, you will need to sign a new consent form. |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature of Client | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Print name | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date |