Consent To Release Medical, Mental Health And Substance Abuse Treatment Information

MR#: Visit#:

DOB:

Patient Information

Patient Name:	Date of Birth:	Phone:
Patient Address:	Dates of Treatment: From: To:	
Sent from:	Send to: Address:	
Attn:	Attn:	
Phone:	Phone:	
Fax:	Fax:	

The Purpose Of Release:

_____ Disability	_____ Financial	_____ Other: Please specify	Program: ☐ Inpatient ☐ Partial Hospitalization ☐ Intensive Outpatient ☐ Medication Management
_____ Continuum of Care	_____ Insurance		
_____ Legal Purpose/Court			

Information to be RELEASED I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information. **Please initial information to be released.**

_____ Substance Abuse History/Treatment	_____ Discharge Summary	_____ Discharge Plan	_____ Medication Information
_____ Discharge Order Form	_____ Psychiatric Evaluation CPE	_____ History and Physical	_____ Benefits/Financial
_____ Drug/Alcohol Test Results	_____ Labs	_____ Verbal Communication	_____ Other

How would you like to receive your information: ☐ Mail ☐ Pick-up ☐ Fax ☐ Email:____

- Upon presentation to pick up information or complete an authorization a request for identification will be made to ensure validity/authority of the receiving party.

In compliance with all State Privacy Statues/Regulations regarding the release of mental health information and Federal confidentiality rules in 42 CFR Part 2 regarding release of substance abuse treatment information:

(1) This consent is subject to revocation at any time, except to the extent that action has been taken in reliance on the patient's consent. **Revocation can be given orally or in writing.**

(2) If not previously revoked, the patient's consent to release mental health and/or substance abuse information will **expire 90 days after the date of this release** unless otherwise noted here: ____

(3) This authorization is in effect until the expiration date, event or condition is met and regardless of whether the patient is still receiving services from the provider.

(4) If requested, the patient is entitled to an accounting of the disclosures of their protected health information.

(5) I understand that my treatment, payment, enrollment, eligibility for benefits will not be conditioned on whether I sign this authorization.

____ ____

Signature Date Name (print)

Patient / Representative

NOTE TO RECEIVER This information has been disclosed to you from information 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 §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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