APPENDIX 1

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

_____

PATIENT NAME

_____

PATIENT DATE OF BIRTH

I,_____ authorize

_____ to disclose to

(Behavior Health Services Provider)

_____

(Name of provider or agency)

_____

The following information: (Client needs to initial each category that applies.)

____ My name and other personal identifying information

____ Assessment

____ Dates of services

____ Recommendations for treatment

____ Progress and compliance with treatment

____ Attendance

____ Date of discharge and discharge status

____ Discharge plan

The purpose of these disclosures is to: Provide permission to the above named Behavior Health Services provider to disclose information as initialed to the above named provider or agency for the coordination of care.

For Clients with Substance Use Disorders: I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that, except for action already taken, I may rescind this consent at any time.

Protected Health Information:

I understand that my alcohol and/or substance use disorder 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 in writing at any time except to the extent that action has been taken in reliance on the consent. I understand that generally _____

(name of substance use disorder treatment program)

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.

If I do not rescind this consent, it expires automatically as one year from the date this consent is signed.

_____

Date signed Client's signature

_____

Date signed Witness Signature

_____ Client has received a copy of this consent form for his/her records.

☐ Client signed consent

☐ Client did not sign consent. Reason _____