There's hope. There's help.®

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

Clear Form

Patient Information		
Patient Name:	Date of Birth:	Phone:
Address/City/State/Zip:	Dates of Treatment:	

Mental Health and/or Substance Abuse Information ☐ TO WHOM ☐ FROM WHOM	Mental Health and/or Substance Abuse Information ☐ TO WHOM ☐ FROM WHOM
Attn:	Attn:
Phone:	Phone:
Fax:	Fax:

The Purpose Of Release:

____ Disability	____ Financial	____ Other: Please specify	Program: ☐ Inpatient ☐ Medication Management ☐ Partial Hospitalization ☐ Intensive Outpatient
____ 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 of patient/legal representative (If POA or Legal representative, Please provide copy of legal documents) Date/Time

_____ _____
Printed Patient Name Date/Time

_____ _____
Witness Signature Date/Time

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.

For Hospital Staff Only:
Information Disclosed:_____ **Date:** _____ **Staff Signature:** _____

Patient – Yellow Medical Records – White