LOGO

CONSENT TO RELEASE RECORDS
CONTAINING SUBSTANCE ABUSE INFORMATION
42 CFR Part 2 and HIPAA

REMEMBER: Information disclosed pursuant to patient consent must be accompanied by the notice prohibiting redisclosure.

Your organization needs to verify this release and your processes are compliant with 42 CFR

I,_____,
[patient's name]

authorize _____
[name or general designation of individual or entity making the disclosure]

to disclose the following:

1. This information will include the following:

____ Psychiatric/medical/alcohol/drug abuse evaluation.

____ Psychiatric/medical/alcohol/drug abuse discharge summary.

____ Progress notes. ____Psychological testing.

____ Psychotherapy notes. ____Educational testing.

____ Lab studies. ____Other:

____ Medical tests/studies. ____Other:

to _____
[name of recipient]

for the purpose of _____.
[describe the purpose of the disclosure; as specific as possible]

I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder 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 understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows:

_____.

[describe date, event, or condition upon which consent will expire, which must be no longer than reasonably necessary to serve the purpose of this consent]

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

_____ I have been provided a copy of this form. *Dated*: _____

_____

Signature of Patient

_____ *Relationship*: _____

Signature of person signing form if not patient

Describe authority to sign on behalf of patient _____

_____