

 AUTHORIZATION TO RELEASE INFORMATION

 Client Name (Please Print) Date of Treatment

 Date of Birth Telephone Number

 Client Address City State Zip

 I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Hereby authorize open communication verbally

 and written between \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and

 \_\_\_\_\_\_\_\_\_

 Party to whom information is to be released Relationship to client

Address City State Zip

This information is being released related to identify, diagnosis, prognosis, and/or treatment. Specific information includes only those items checked below:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Acknowledgement of Admission |  | Diagnosis |
|  | Reviewing Status In Treatment |  | Information to Refer to Other Services |
|  | History and Physical |  | Physician's Orders |
|  | Chemical Dependency Evaluation |  | Assessments |
|  | Laboratory Reports |  | Psychological Testing/Evaluation |
|  | Consultation Reports |  | Discharge Summary |
|  | Other not specified: |

The Purpose of this disclosure is for assessment and planning for current treatment.

Please Note: These records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2, and Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. No authorization is given for further release of these records to any other third party. Client Initial \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Revocation: This Release of Information is subject to revocation by the under-signed at any time except to the extent that information has already been disclosed based on authorization contained herein. Unless further limited by date stated here, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_this Release of Information will automatically expire after a period of 180 days from date signed. Client Initial \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I further authorize that a photocopy of this document is acceptable as an original. Client Initial

I agree that Oregon Trail may not condition my treatment whether I sign this consent but that in limited circumstances I may be denied treatment if I do not sign consent form. Client Initial \_\_\_\_\_\_\_\_\_\_

Signature of Client Date

Signature of Therapist/Staff Date

Mandatory Disclosures

42 CFR Part 2 allows for disclosure where the state mandates child-abuse-and neglect reporting (42 C.F.R. § 2.12(c)(6);

45 C.F.R. §164.512(b)(1)(ii)); when cause of death (42 C.F.R. § 2.15(b)) is being reported; or with the existence of a

valid court order.

Permitted Disclosures

Programs are permitted to disclose patient-identifying information in cases of medical emergency (45 C.F.R. § 164.506(c)

; 42 C.F.R. § 2.51); in reporting crimes that occur on program premises or against staff (45 C.F.R. § 164.502(j)(2), 164.512(f)(2); 42 C.F.R. § 2.12 (c)(5)); to entities having administrative control (45 C.F.R. § 164.502(a)(1), 164.506(a),

(c); 42 C.F.R. § 2.12 (c)(3)); to qualified service organizations (45 C.F.R. § 160.103, 164.504(e), (c); 42 C.F.R. § 2.12 (c)

(4)); and to outside auditors, evaluators, central registries, and researchers (45 C.F.R. § 164.501, 164.506, 164.512; (c); 42 C.F.R. § 2.53 (c)-(d); 42 C.F.R. § 2.52; 45 C.F.R. § 164.512(i)(1)(ii)).

Authorization of Release of Information from patient records, Oregon Trail Recovery