Authorization to Disclose/Obtain Confidential Information

Name of Client:_____ date of birth: _____/_____/_____

In accord with Federal Regulations 42 CFR, Part 2, and HIPAA, I hereby authorize Helping 2 Overcome Systems LLC (H2O) to:

(Check one or <u>both</u> of the following boxes) - **Obtain from:** ☐ **Release/Disclose to:** ☐

Name of Individual/Entity to whom disclosure is to be made:_____

Address (City/State/Zip): _____

Circle all that apply: Phone and Fax Number:_____

Diagnostic Assessment | Treatment Plan | Discharge Summary | Legal History
Urinalysis Results | Other:_____

For dates of service including: **from:** _____/_____/_____ **to:** _____/_____/_____

(Including psychiatric records related to emotional illness, and information regulated by Federal Public Law 930-282, confidentiality of alcohol and drug abuse clients. Also included are records documenting the diagnosis and/or treatment of AIDS/AC, HIV Positive and other related diseases.)

PURPOSE FOR DISCLOSURE (CHECK ONE or MORE)

Comprehensive Treatment | Family Involvement | Aftercare/Follow-up
Legal Issues | Other (i.e-urine screens/toxicology)

CONFIDENTIALITY RULES: This information has been disclosed to you from records 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 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 for any patient with a substance use disorder, except as provided at §§2.13(c)(5) and 2.65.

I understand that the information disclosed is protected by law and may not be re-disclosed without my written authorization by law; however, I understand that Helping 2 Overcome Systems LLC (H2O) cannot control the recipient's use of the information.

You may revoke this authorization at any time except to the extent that action has been taken in reliance thereon.

Authorization to disclose shall automatically expire in 6 (six) months or 180 days after the date of authorization unless:

(Check box) – ☐ **I expect to continue receiving treatment services beyond the 180 days and extend the authorization to a maximum of one year (365 days) or at termination, whichever is sooner)**

Original Expiration Date (from above) is: _____/_____/_____ - if Condition occurs, Date: _____/_____/_____

_____ _____
Name of Staff facilitating this request (please print) Signature of staff facilitating this request

<u>Disclosure Authorization</u> (Signatures)

Client (signature): _____ Date: _____

Parent/Guardian (sign): _____ Date: _____

Describe Relationship: _____

<u>Revocation if/when requested:</u>

I, _____ hereby revoke this consent for the release of the above information on: _____/_____/_____

Client Signature:_____

Staff Signature:_____