GENERAL RELEASE OF INFORMATION

I, ________________________________ authorize ____
(Name of Patient) (Name or general designation of alcohol/drug program making disclosure)

to disclose to ____
(Name of person or organization to which disclosure is to be made)

the following information____
(Nature and amount of information to be disclosed; as limited as possible)

____

The purpose of the disclosure authorized in this consent is to:

____
(Purpose of disclosure, as specific as possible)

I understand that my alcohol/drug treatment record s are protected under the Federal regulation governing Confidentiality of Alcohol 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, Parts 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for the regulations. I also understand that I may revoked this consent at any time expect to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

____
(Specification of the date, event, or condition upon which this consent expires)

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.

________________________ ____
Date Signature of patient or person authorized to sign for patient

________________________ ____
Date Witnessed Witness

PROHIBITION OF REDISCLOSURE OF CONFIDENTIAL INFORMATION

This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules (42 C.R.F. Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is **not** sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

CRIMINAL JUSTICE RELEASE AUTHORIZATION

I, ______________________________________, authorize _________________________________
Name of Patient   Name of Program
to communicate with:

___ ____
The Name of Probation/Parole Department and employee supervising my case,

___ ____
Name of Judge and appropriate court

___ ____
Other

To communicate with and disclose to one another the following information (nature and amount of the information as limited as possible):

___ my diagnosis, urinalysis results, information about my attendance or lack of attendance at treatment or lack of attendance a treatment sessions, my cooperation with the treatment program, prognosis, and

___ ____

The purpose of the disclosure is to inform the person(s) listed above of my attendance and progress in treatment.

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol 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. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

This could be one of the following:

___ there has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated into treatment, or

___ ____
(Specify other time when consent can be revoked and/or expires)

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 further understand that if I revoke this release form the court may otherwise terminate me from the criminal justice program.

I have been provided a copy of this form.

_________________________   ____
Date   Signature of patient or person authorized to sign for patient

_________________________   ____
Date Witnessed   Witness

PROHIBITION OF REDISCLOSURE OF CONFIDENTIAL INFORMATION

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