Family Service D&A Treatment/Service Provider ROI

Client Name:

Date of Birth:

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 Code of Federal Regulations (CFR) Part 2, and the 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. 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.

I authorize Family Service to disclose my protected health information to the following person or entity (name/agency/phone number):

_____

This authorization allows Family Service to communicate with and/or release records for the following purpose(s):

- ☐ Continuity and Coordination of Care
- ☐ Substance Use Treatment Information

This authorization covers the following information about me:

- ☐ Substance Use Treatment Information
- ☐ Screening and Lab Results
- ☐ Current Medication/Prescription Records
- ☐ Diagnoses and Dates of Services
- ☐ Evaluations and Assessments
- ☐ Treatment and Discharge Recommendations

Note to receiving facility: 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 this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains 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. The Federal rules restrict use of information to criminally investigate or prosecute any alcohol or drug abuse patient.

I understand that Family Service may not require that I sign this authorization in order to obtain treatment.

I have read this authorization or had it explained to me, and I understand its contents.

I accept a copy of this authorization: **Yes** or **No** (please circle)

In the absence of revocation, I authorize this release of information to become effective on: _____
and to expire on: _____ (date no longer than 1 year)

_____ _____

Client Signature **Date**

_____ _____

Staff/Witness Signature **Date**