

Family Service ROI – Legal/Funder

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/relationship/phone number):

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

- Continuity and Coordination
- Recommendations

This authorization covers the following information about me:

- Presence in Treatment - attendance
- Prognosis –impact of treatment
- Nature of Project - agency and service information
- Progress – brief description
- Relapse - status and frequency

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.

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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