**CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION**

I, \_\_\_\_<client name>\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize

\_\_\_<agency name, address>\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency Address, City, State

to disclose to

\_\_\_<agency name, address>\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency Address, City, State

the following information for activities/services within the indicated date ranges:

< consented activity, date range>

< consented activity, date range>

< consented activity, date range>

< consented activity, date range>

< consented activity, date range>

*I understand that my records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Pts. 160 & 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, and that in any event this consent expires automatically as indicated with each disclosure item above. I understand that generally* ***<Agency name>*** *may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I understand that the information in my health record may include information relating to acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. Exchange of information ensures continuity of care between providers. By not sharing information, my health care could be compromised.*

*I hereby authorize the use or disclosure of my health care and/or other information as described above. I understand that this authorization is voluntary. I understand that I may revoke this authorization at any time by notifying the individual(s) or organization releasing this information in writing, but if I do, it won’t have any effect on actions taken on this authorization before my revocation was received. I understand that the individual(s) or organization releasing this information will not condition my treatment, payment, enrollment in a health plan (if applicable) or eligibility for benefits on whether I provide this authorization. I understand that if the person(s) or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipient of this information must continue to keep this information confidential.*

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

Signature of Participant Date

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

Signature of Witness Date

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

Signature of Parent or Legal Guardian Date

**CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS**

*The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by Federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser unless:*

*(1) The patient consents in writing; OR*

*(2) The disclosure is allowed by a court order; OR*

*(3) The disclosure is made to medical personnel in a medical emergency or to a qualified personnel for research, audit, or program*

*evaluation; OR*

*(4) The patient commits or threatens to commit a crime either at the program or against any person who works for the program.*

*Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to the United States*

*Attorney in the district where the violation occurs.*

*Federal law and regulations do not protect any information about suspect child abuse or neglect from being reported under state law to appropriate state or local authorities. (See 42 U.S.C. Sec. 290dd-2 for Federal law and 42 CFR Part 2 for Federal regulations.)*

*Legal Action Center. (1996) Handbook on legal issues for school-based programs (Revised). pp. 71, 72, & 74. New York: Author.*

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**PROHIBITION on REDISCLOSURE of INFORMATION CONCERNING CLIENT in ALCOHOL or DRUG ABUSE TREATMENT**

*If the information released pertains to alcohol/drug abuse treatment, this is 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 the 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 any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.*