Vision, Hope, and Strength for a Better Life

AUTHORIZATION FOR RELEASE OF INFORMATION
For Ongoing Collaborative Service Providers

I, _____, of _____,
(Client's Name) (Client's Address)

Authorize: Center For Family Services: Program: _____

_____
(Address) (Phone #) (Fax #)

And: _____
(Name of Organization / Name of Service Provider)

_____
(Names of persons at listed entity, if an established treating provider relationship does not exist)

_____
(Address) (Phone #) (Fax #)

To disclose and exchange the following information *(describe how much and what kind of information may be disclosed, including an explicit description of what substance use disorder information may be disclosed; as limited as possible)*:

_____

_____

For the following purpose *(describe the purpose of the disclosure; as specific as possible)*: _____

_____

I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder 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, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. 42 C.F.R. Part 2 prohibits unauthorized disclosure of these records.

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 further acknowledge that the information to be released was fully explained to me and this consent is given on my own free will. Client has been provided a copy of this form.

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.

This authorization to release information will expire, if not revoked by me, in one year, or on the following date:

_____
(Expiration Date – not to exceed 365 days)

_____ _____
Signature of Client Date Signature of CFS Staff Date

_____ _____
Signature of Parent / Guardian Date Description of Authority if signing on behalf of client

NOTICE TO RECIPIENT

This information has been disclosed to you from records, which may be 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 individual with substance use disorder."