REGION II HUMAN SERVICES
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION
Program: Adult Support Services

I, _____ date of birth_____
[*Patient's name*]

Authorize _____
[*Name or general designation of individual or entity*]

☐ Disclose protected health information to _____
☐ Receive protected health information from _____
☐ **This permission is at the patient's request; OR**
☐ **This permission is for treatment, payment, or health care operations (administrative) purposes such as diagnosis, therapy, referrals for treatment, rehabilitation, care coordination and/or delivery of other services, billing and collecting for services, or overseeing the quality of care provided. Disclose protected health information to my treating providers, health plans, third-party payers, and people helping to operate this program.**

Indicate the types of records covered by this Authorization:

___ Assessment	___ Diagnosis	___ Medication Management Information
___ Psychological Evaluation	___ Education Information	___ Medical Records
___ Social History	___ Entire record, except progress notes	___ Discharge / Transfer Summary
___ Demographic Information	___ Psychiatric Evaluation	___ Behavior programs and information
___ Vocational testing results	___ Drug & Alcohol Use	___ Treatment Plan/Summary Reports

___ Current TX Update, Progress, Participation
___ any disclosures selected above may include information pertaining to substance use disorder records
___ Other _____
[*Other disclosure; as specific as possible*]

I understand that only the above specified information can be disclosed by the above specified organizations.

I understand that my substance use disorder records are protected under the Federal regulations governing the Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2 ("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. If a recipient of my records is a covered entity or business associate and my information has been disclosed for purposes of treatment, payment, or health care operations purposes (administrative activities), my information may be redisclosed in accordance with the permissions contained in the HIPAA regulations, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against me. My information may be subject to redisclosure and no longer protected by Part 2 or HIPAA.
I understand that I may revoke this authorization at any time by sending a letter to the Privacy Officer of the organization disclosing my information, except to the extent that action has been taken in reliance on it. This consent will expire in one (1) year from the date I sign it or as follows: _____
[*Describe date, event, or condition upon which consent will expire, which must be no longer than reasonably necessary to serve the purpose of this consent*]

- I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment nor will it affect my eligibility for benefits.
- I affirm that everything in this form that was not clear to me has been explained and I believe I now understand all of it. I have been provided a copy of this form.

Dated: _____

_____
Signature of Client

_____
Signature of Personal Representative

_____
Describe authority to sign on behalf of client

_____
Signature of Witness