REGION II HUMAN SERVICES

AUTHORIZATION FOR *TREATING PROVIDER* RELEASE OF INFORMATION

I,____, date of birth_______________
[client's name]

authorize ____
[name or general designation of individual or entity making the disclosure]

to disclose ____
[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]

to ____
[name of recipient entity, which has a treating provider relationship with the client]

for the purpose of ____.
[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.

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. Unless I revoke my consent earlier, this consent will expire automatically 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 understand that I may inspect and have a copy of the health information described in this authorization.

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