

RECOVERY CENTER MISSOULA
AUTHORIZATION TO RELEASE INFORMATION

NAME: _____ DOB: _____ SSN: _____

Hereby authorizes Recovery Center Missoula to the following (initial all that apply) via the following means:

____ RELEASE TO ____ OBTAIN FROM
____ ELECTRONIC ____ VERBAL ____ WRITTEN

Name: _____ Relationship: _____

Agency: _____

Address: _____

Phone: _____ FAX: _____ e-mail: _____

Specific Information to be RELEASED or OBTAINED (initial all that apply):

<input type="checkbox"/>	ACT Records	<input type="checkbox"/>	Discharge Medications	<input type="checkbox"/>	Pre-Sentence Investigation
<input type="checkbox"/>	Admission/Compliance Status	<input type="checkbox"/>	Discharge Summary	<input type="checkbox"/>	Progress Notes/MD Notes
<input type="checkbox"/>	Bio-Psych-Social Info.	<input type="checkbox"/>	Family Program Info	<input type="checkbox"/>	Progress Report
<input type="checkbox"/>	Continued Stay Reviews	<input type="checkbox"/>	History/Physical	<input type="checkbox"/>	Psychiatric Evaluation/Records
<input type="checkbox"/>	Continuing Care Plan	<input type="checkbox"/>	Intake/Assessment Summary	<input type="checkbox"/>	Treatment Plan
<input type="checkbox"/>	Demographic Info	<input type="checkbox"/>	Lab Tests (re-release)	<input type="checkbox"/>	Treatment Recommendations
<input type="checkbox"/>	Diagnostic Impressions	<input type="checkbox"/>	Presence in Treatment	<input type="checkbox"/>	

____ Re-Release of Records (Specify Record(s): _____)

____ I understand this could include information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Syndrome Virus), Psychiatric or Mental Health Care, Treatment for alcohol and/or drug abuse.

PURPOSE FOR DISCLOSURE:

____ I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

____ I understand that I may revoke this consent in writing 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 follows:

(Specify the date, event, or condition upon which this consent expires)

____ To revoke this authorization, I must submit a written request to the Clinical Records Department of **Recovery Center Missoula**. I understand that the revocation will not apply to information that has already been released in response to this authorization.

____ I understand that generally **Recovery Center Missoula** 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 any disclosure of information carries with it the potential for an unauthorized disclosure and the information may no longer be protected by federal confidentiality rules.

____ I have received a copy of this authorization and the Privacy Rights Notice

CLIENT SIGNATURE: _____ Date: _____

GUARDIAN SIGNATURE: _____ Date: _____

WITNESS SIGNATURE: _____ Date: _____

NOTICE TO WHOMEVER DISCLOSURE IS MADE: This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. 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 C.F.R. 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.