Master Center

D-4B Release of Information (ROI) Justice Involved

I, _____ Date of Birth: _____
[print patient's name]

Authorize **Master Center for Addiction Medicine to** ☐ disclose to and/or to ☐receive the information below:

Contact Information Receiving and/or Releasing Information:

Probation/Parole Agency_____
District/Jurisdiction (Required) _____
Including: The patients *currently assigned supervising officer, acting officer, or designee* within the above district/jurisdiction
Optional (for routing purposes only – changes do NOT require a new ROI):
Officer Name (if known) _____
Phone: _____ Fax: _____Email:_____

Purpose of release (Check all that apply)

☐ Coordination of care with supervising authority
☐ Verification of treatment participation
☐ Compliance with conditions of probation/parole
☐ Supervision requirements
☐ Court or legal reporting requirements
☐ Other (specify):
_____

Information Authorized for Disclosure

All of my substance use disorder information and/or medical history: Initial _____

Or only the following (Initial each category that applies):

Enrollment status (active, discharged, referred)	_____	Attendance and appointment compliance	_____
Level of care (e.g., IOP, MAT)	_____	Treatment participation status	_____
Missed appointments / noncompliance notifications	_____	Treatment summaries (non-psychotherapy notes)	_____
Psychiatric Treatment Notes	_____	Urine drug screen results	_____
Discharge Summary	_____	Medications	_____
Other (specify)	_____		

Dates of information to be disclosed: ☐All dates of service ☐ Specific Dates: (Start) _____ **-** (End)_____

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of 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. Parts 160 and 164, and cannot be disclosed without my writtenconsent unless otherwise provided for by the regulations. I may revoke this consent in writing at any time. I understand that the revocation will not be effective retroactively for information disclosures that have already occurred. A change in probation/parole officer or office location within the same listed district/jurisdiction does NOT require a new authorization. A new authorization is required if the probation/parole **district or jurisdiction changes** or if the scope of disclosure changes. I understand that I may be denied services if I refuse consent of disclosure for purposes of treatment, payment, or healthcare operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I understand this Release of Information is effective throughout my treatment and will remain active and valid for the duration of my probation/parole supervision or until 60 days after discharge (whichever comes first); unless a specific date is noted here ___/____/____; or until revoted in writing.

Patient's Signature: _____**Date:** _____

If the individual is unable to sign due to legal incapacity, the signature of the individual's personal representative is required. Documentation of the personal representative's legal authority **must** be attached.

Signature of Personal Representative: _____Print: _____
Date:_____ Legal Authority: _____

REVOCATION OF AUTHORIZATION FOR RELEASE OF INFORMATION

Authorization Being Revoked

I am revoking my previously signed Authorization for Release of Information. This revocation applies to **all future disclosures** of my protected health information unless otherwise required by law or court order.

By signing below, I understand that:

- Revocation is effective **only upon receipt** by the treatment provider.
- Revocation **does not apply retroactively** to information already disclosed prior to receipt.
- Certain disclosures may still be required by law, regulation, or court order.
- If disclosure was required as a condition of probation/parole, revocation may impact my legal supervision requirements.

Patient Signature: _____
Printed Name: _____
Date: ____ / ____ / _____