

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

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

Person/Organization Contact Information Receiving and/or Releasing Information:

Name of Person/Organization _____
Phone: _____ **Fax:** _____ **Email:** _____
Relationship to you: _____

Information to be disclosed:

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

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

Evaluation/Assessments Reports _____	Treatment Dates/Attendance _____
Psychiatric Progress Notes _____	Medication(s) _____
Medical Progress Notes _____	Lab Results _____
Clinical Progress Notes (Therapy) _____	IOP Progress Notes _____
Referrals _____	Discharge Notes _____
Other _____	_____

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

Purpose of release: Continuity of care Coordinating treatment Payment/ Insurance Probation
 Other _____

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 written consent 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.

I understand this Release of Information is effective throughout my treatment and will remain active and valid for one year from the date of signature OR until 60 days after discharge (whichever comes first) OR until a specific date as listed on the form specific date as listed here: _____

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 that I may cancel this authorization at any time except to the extent that action has been taken in reliance on it. I understand that if I cancel this consent, I must do so 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: _____

I am **revoking** this Consent for the Release of Confidential Health Information by signing below.
 Patient Revocation: _____ Date Revoked: _____