

AUTHORIZATION FOR THE RELEASE/ EXCHANGE OF INFORMATION



Client Name _____

Client # _____

Person/Agency/Facility releasing/exchanging information:
(Include name and address)

All staff involved with my case that work at the following agency: _____

Fax #: _____ **Phone #:** _____

I, _____, voluntarily authorize and request the release/exchange (including paper, oral, and facsimile interchange) of the specified information between Anuvia and the above-named person/agency/facility.

This data shall include **patient identifying information, all of my substance use disorder records to include: assessment, diagnosis information, results of urinalysis and breathalyzer tests, status, progress, attendance, and compliance with treatment plan, prognosis, prescribed medications, medication compliance, recommendations, aftercare plan, referrals, admission and discharge summaries, mental health conditions and medical conditions.**

The purpose of the disclosure authorized in this is to **provide information and coordinate services in regard to your case.**

The purpose of the disclosure authorized in this is to Provide Information and Coordinate Services. The doctrine of informed consent has been explained to me and I understand the contents to be released, and the need for the information. I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Client 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 pursuant to 42, C.F.R. Part 2, I have a right to receive a list of entities to which my patient identifying Part 2 information has been disclosed. I also understand that I may revoke this consent in writing at any time except to the extent that reliance has been taken upon it (information that was released prior to this consent being revoked cannot be unrevealed). This consent expires automatically 365 days from the date of signature below, or at an earlier date or event specified: _____ .

I understand that Anuvia may not condition my treatment on whether I sign a consent form.

Client Signature _____ **Date**

Legal Guardian _____ Date

Witness _____ Date

This information has been disclosed to you from records protected by Federal confidentiality rules (42CFR 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 a person to whom it pertains or as otherwise permitted by 42CFR 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.