**Consent For The Exchange / Release Of Confidential Information**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(D.O.B.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_),

(Name of client)

Authorize

**Gratitude Behavioral Health LLC**

(Name or general designation of alcohol/drug program making exchange of information)\

to disclose to or request from

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(**Name of person or organization to which information is to be exchanged with**)

the following information:

□ Evaluation □ Treatment Recommendations

□ Participation □ Compliance / Non-Compliance

□ Urinalysis Results □ Billing Information

□ Discharge Information □ Self Help Attendance

□ Mental / Medical Health □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The purpose of this exchange as authorized in this consent is to: To support and monitor clients treatment

(Purpose of exchange, as specific as possible)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol 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. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also 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:

1 (one) year from date of discharge\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

I understand that generally Gratitude Behavioral Health, LLC may not condition my treatment on whether I sign a consent form, but that incertain limited circumstances I may be denied treatment if I do not sign a consent form.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Signature of Client

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Signature of Parent or Guardian

  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Witness to Signature

**PROHIBITION OF DISCLOSURE**

This information has been released to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibits you from making further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise specified by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules may restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.