UNIVERSAL AUTHORIZATION FOR THE EXCHANGE OF CONFIDENTIAL INFORMATION

I, ____, authorize
Last Name First Name M.I.

____ AND

____ AND

____

To communicate with and disclose to one another the following information about me (only check categories of information necessary for purpose of disclosure)

______My treatment history, including mental health and/or addiction services (excluding psychotherapy notes)
______My name, contact information and other personal identifying information
______Treatment Dates
______Discharge Summary/Continuing Care Plan
______Initial and subsequent evaluations of my service needs
______Billing information
______Recommendations/Prognosis
______Other: ______________________________

The purpose of this exchange of information is (limit to necessary purposes):

______Evaluate my need for services and coordinate and provide those services to me
______ Family Involvement
______ Payment for my services
______ Report my attendance and compliance with treatment to the Court
______ Satisfy legal requirements
______ Coordinate and plan for any crisis events I may experience
______ Other: ______________________________________

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 (45 C.F.R. Parts 160 and 164) "HIPAA" and cannot be re-disclosed to a third party without my written authorization unless permitted by the regulations. I also understand that my mental health treatment records are protected by HIPAA but that if the recipient of my information is not subject to HIPAA, it may no longer be protected by state or federal law and therefore subject to re-disclosure to a third party.

I understand that I may revoke this authorization at any time, except to the extent that the entity(ies) authorized to make the disclosure taken action in reliance on it. Unless revoked earlier, this authorization will expire one year from date of signature OR as otherwise specified: On this date: ____________________ OR this event: ________________________________

This is a free and voluntary act by me. I understand that I may refuse to sign this authorization, if it is for purposes other than alcohol and/or drug treatment and payment for that treatment, and that my refusal to sign it for other purposes will not otherwise affect my ability to obtain treatment, my eligibility for benefits, or the payment provided for those services. I understand that refusing to sign this form does not prohibit disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.

______________ ____ ______________
Date Signature of Client/Legal Representative Client Date of Birth

Printed name and authority of person signing on behalf of Client: ____

NOTICE TO RECIPIENTS OF ALCOHOL AND/OR DRUG TREATMENT INFORMATION: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65.