



AUTHORIZATION TO DISCLOSE/OBTAIN CONFIDENTIAL INFORMATION
EMERGENCY CONTACT

Name of Client: _____ Date of Birth: __/__/____

The following programs are authorized to: disclose ___ receive or ___ exchange information ___
Specify: _____

Program Authorized to Make Disclosure: _____

Authorized Individual/Organization to Whom Disclosure is made _____

Purpose of Disclosure: Coordinate treatment Assessment information for treatment planning
Gather Information for Ongoing Treatment
Other purposes (Specify) _____

Type of Information to be Disclosed: Progress notes Diagnostic Assessment Treatment Progress
Lab Results/Urine Testing Attendance HIV/AIDS Testing or Status Pregnancy Testing/Prenatal
Care Diagnosis Mental Illness Information/Treatment Other Information (specify) _____

Amount of Information to be disclosed for Dates of Service: From: __/__/____ to: __/__/____

This Authorization Expires (Specify Event, Date and/or Condition): _____

Signature of Client or Other Person Authorized to Permit Disclosure _____ Date: __/__/____

Signature of Staff or Witness _____ Date: __/__/____

Revocation: This authorization is subject to written revocation at any time except to the extent the program or person who is to make the disclosure has already acted in reliance on it.
I hereby revoke consent: _____ Date: __/__/____
Signature of Client Signature _____ Date: __/__/____
Signature of Staff or Witness _____ Date: __/__/____

Prohibition against Re-Disclosure: This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R., 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 information to criminally investigate or prosecute any alcohol or drug abuse client. Drug abuse patient records are also protected under the Health Insurance Portability and Accountability Act of 1996 [HIPAA], 45 C.F.R., parts 160 and 164. [These conditions apply to every page disclosed and a copy of this authorization will accompany every disclosure.]



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**AUTHORIZATION TO DISCLOSE/OBTAIN CONFIDENTIAL INFORMATION
CRIMINAL JUSTICE SYSTEM REFERRAL**

I, _____, hereby consent to communication between
(Client Name)
The Recovery Center of UMADAOP Lucas County and _____
(Criminal Justice Agency)

The purpose of and need for the disclosure is to inform the criminal justice agency listed above of my attendance and progress in treatment. The extent of information to be disclosed is my diagnosis, information about my attendance or lack of attendance at treatment sessions, my cooperation with the treatment program, prognosis, and other information as listed below:

I understand that this consent will remain in effect and cannot be revoked by me until:

- There has been a formal and effective termination
- The revocation of my release and signature below
- My release from confinement, probation, or parole
- Other proceeding under which I was mandated into treatment
- Other: _____

(Specify other time when consent can be revoked and/or expires)

I also understand that any disclosure made is bound by the federal law and regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records [42 U.S.C. '290dd-2; 42 C.F.R. Part 2] and that recipients of this information may re-disclose it only in connection with their official duties.

Signature of Client or Other Person Authorized to Permit Disclosure Date: ___/___/___

Signature of Staff or Witness Date: ___/___/___

Revocation: This authorization is subject to written revocation at any time except to the extent the program or person who is to make the disclosure has already acted in reliance on it.

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