NEW CONCEPTS AUTHORIZATION FOR DISCLOSURE AND RECIPROCAL EXCHANGE OF INFORMATION

Name **Date of Birth**

First Last

I,

Write your full name

authorize: New Concepts, 111 South Byrne Rd. Toledo, OH, 43615 to disclose to, receive from and communicate with:

Individual/Organization for Lawful Holder; Program/Agency for Treating Provider; Complete Address

regarding my current, past and future services (including substance use disorder services/ information)

Check all boxes to specify information to be included in release:

☐ Clinical Assessment/Diagnosis/Recommendations ☐ Treatment/Service Plan

☐ Discharge Summary ☐ Progress Reports

☐ Acquired Immunodeficiency Syndrome (HIV) ☐ Psychiatric Evaluation

☐ Medical History ☐ Behavioral Health History

☐ Results of UDS/Lab Reports ☐ Medications

☐

The purpose of disclosure is:

☐ Continuity of care between providers

☐ Information for court/judicial/attorney/school

☐ Information for billing purposes

☐

I understand if my record contains HIV infection, AIDS or AIDS related conditions information it can only be disclosed in accordance with the communicative disease as specified in GS 130A-143. New Concepts will only disclose information when you sign specifically for release of HIV/AIDS release.

I understand 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, 2018 and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164 and under state law. I understand I may revoke this authorization by written request at any time. I understand the revocation will not apply to information already released in response to this authorization.

The date, event or condition upon which this consent expires:

This authorization expires one year from the signature date.

- *I certify that this authorization is made freely, voluntarily, and without coercion. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.*
- *I understand information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.*
- *I hereby release New Concepts, its affiliates, agents, and representatives from all legal liabilities resulting from the release of this arising from or related to disclosure of information according to this request.*

Client/Legally Responsible Person/Personal Representative Signature:

Date:

Witness/Staff Signature:

Date:

Notice to Recipient: 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 2018. 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.

Are you seeking to withdraw consent:

○ Yes ⊙ No