Sample Consent for Release of Confidential Information

I, John Doe, authorize
(Name of Patient)

ABC Recovery Center and the Washington State Division of Behavioral Health and Recovery
(Name or general designation of alcohol/drug program making disclosure)

to disclose to the Banks Lake BHO
(Name of person or organization to which disclosure is to be made)

the following information: Identifying information, admission date, initial clinical assessment,
(Nature and amount of the information to be disclosed, as limited as possible)

service history of substance use disorder assessments, treatment activity, and service encounters including provider information and dates of service, individual service plan, anticipated discharge date, and discharge information if applicable.

The purpose of the disclosure authorized in this is to: Support coordination of care, payment,
(Purpose of disclosure, as specific as possible)
and health care operations.

❻ I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent 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:

October 1, 2016 (If needed, extend based on coordination of care)
(Specification of the date, event, or condition upon which this consent expires)

❿ I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.
I have been provided a copy of this form.

Dated: ❾ ❽
Signature of Patient

Signature of person signing form if not patient

Describe authority to sign on behalf of patient