Helena Valley Addiction Services

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www.helenavalleyaddictionservices.com

AUTHORIZATION FOR THE DISCLOSURE OF HEALTH INFORMATION

I, (Your Name) ____ DOB________________

Authorize HVAS to release to, obtain from, or exchange with:

____
(Name of: Court, Parole Officer, Case Worker, Attorney, CPS, Agency, Treatment Center, etc.)

I request the release of the following specific information (circle all that apply):

CD Evaluation	Psychiatric Evaluation	Progress Notes
History/Intake	Medication History	Treatment Summary
Diagnosis	Attendance	Collateral Information
Psychological Test Results	Progress in Treatment	Other__________

for the purpose of:

___evaluation/assessment ___coordinating treatment efforts ___personal use ___other

I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in 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 one year from the date of my signature unless a different date is stated. Specify new date_______________(optional).
I understand that information disclosed by this authorization, except the Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer by protected by the Health Insurance Portability and Accountability Act Privacy Rule {45 CFR Part 164}, and the Privacy Act of 1974 {5 USC 552a}.
I release HVAS from liability and claims of any nature pertaining to the disclosure of requested protected health information pursuant to this authorization.

____ Social Security #:___________________
Signature of Client Date

____
Signature of Witness Date

TO RECIPIENT: 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 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 CFR 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 the information to criminally investigate or prosecute any alcohol or drug abuse patient.

AUTHORIZATION EXTENSIONS

I hereby confirm that I have reviewed this consent form and agree to its extension for an additional:

Check One:

_____ 6 months OR

_____ other (specify) ___________________________

Client	Date	Witness	Date

Check One:

_____ 6 months OR

_____ other (specify) ___________________________

Client	Date	Witness	Date

Check One:

_____ 6 months OR

_____ other (specify) ___________________________

Client	Date	Witness	Date