

Authorization to Obtain and Release Information

Name of Client: _____ **DOB:** _____

Signature of Client: _____

This will authorize Benchmark Transitions to disclose to and/or obtain from:

Name of Person or Organization: _____

Relationship: _____

Address & Phone number: _____

The following information:

Description of Information to be Disclosed *(Client should initial each item to be disclosed)*

| | |
|----------------------------------|---|
| _____ Assessments | _____ Cooperation/Motivation |
| _____ Discharge/Transfer Summary | _____ Financial Information |
| _____ Medication | _____ Nursing/Medical Assessment |
| _____ Presence in Treatment | _____ Prognosis |
| _____ Progress in Treatment | _____ Psychiatric Evaluation |
| _____ Psychosocial Evaluation | _____ Toxicological Reports/Drug Screen |
| _____ Treatment Plan or Summary | _____ Other: _____ |

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and, when appropriate, coordinate treatment services. If other purpose, please specify: _____

Expiration

Unless sooner revoked, this consent is valid for **12 months** due to the need for ongoing communication for the coordination of treatment, or at termination of treatment.

Conditions

I understand that Benchmark Transitions will not condition my treatment on whether I give authorization for the requested disclosure. The consequences of refusing to sign this authorization have been explained to me.

Form of Disclosure: Unless you have requested in writing that disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner we deem to be appropriate and consistent with applicable law, including but not limited to verbally, in paper format, or electronically.

RE-DISCLOSURE

"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 in NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse Client." I may request a copy of this authorization for my records.

I understand that my records are protected under Federal Confidentiality regulations (42 CFR Part 2). Published August 10, 1987, and the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. Seq, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that my medical record may contain information concerning my psychiatric, psychological, drug and alcohol abuse, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions. (Under the Mental Health Code, release of mental health records must be germane to the purpose and need for disclosure).

RIGHT TO REVOCATION

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Benchmark Transitions. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.