Release of Information

REVOCATION CLAUSE: I understand that I have the right to revoke this authorization at any time but must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization.

Verbal Revocation Clause: All revocation must be in writing unless the revocation is for Substance Abuse Treatment

in which case verbal revocations is acceptable.

Re-disclosure: Notice to accompany disclosure. Each disclosure made with the patient's written consent must be accompanied by the following written statement:

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.

I understand that my substance use disorder records are protected under the Federal regulations governing.

Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

Conditions: I further understand that Confianza Health will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have limit Confianza Health and/or staff members to fully coordinate services on my behalf. I also understand that after information is released to the authorized party, Confianza Health no longer has any control over the information provided.

I authorize Confianza Health to disclose the information listed below through verbal or written communication. (check all that apply) *

- ☐ Treatment information
- ☐ Mental health records (assessment/evaluations, treatment plans, psychotherapy notes, progress updates)
- ☐ Billing/claims information
- ☐ Decline to Release Information

Other

This information will be used for the following purposes. (check all that apply) *

- [ ] Coordination of care
- [ ] Legal purposes
- [ ] Personal use
- [ ] Crisis intervention or safety planning
- [ ] Referrals to other providers
- [ ] Court-ordered requirements
- [ ] Attorney requests for records
- [ ] Child welfare or DCS coordination
- [ ] Disability or benefits applications (SSI/SSDI, AHCCCS, VA, etc.)
- [ ] Decline to Release Information

Other

Please provide the name of the person you would like us to coordination with on your behalf or N/A. *

Please provide the contact information of the person you would like us to coordination with on your behalf:

This information comes from confidential files and is not allowed, by law, to be disclosed without the written consent of the affected person. Records of substance abuse are only disclosed with written consent by (42CFR Part 2). Information relatedto contagious diseases, conforms to this form, cannot be disclosed without any specific written authorization ASR 36-664. H.)

PLEASE INITIAL HERE IF YOU DO NOT CHOOSE PROVIDE A RELEASE OF INFORMATION

Person signing document *

Signature: * ×

Date: