AUTHORIZATION TO RELEASE AND EXCHANGE TREATMENT INFORMATION FOR LEGAL ENTITIES

COMMUNITY REACH CENTER

Nextgen MRN: _____

Consumer name: _____ **DOB:** _____ (MM/DD/YYYY)

Release To/From: Community Reach Center is hereby authorized to release, exchange, and share oral and written substance use disorder and mental health treatment information with the criminal justice system entities named.

Release To/From:
Specific Entity or Person Authorized: _____

_____

_____
Address:

(_____) _____ – _____ **Phone:**

(_____) _____ – _____ **Fax:**

_____
Email:

Case Number (if applicable):_____

Purpose(s) or need for which the information is to be used and disclosed:

By signing below, I authorize the disclosure of my substance use disorder and mental health treatment records to be used in legal proceedings that may include criminal, civil, legislative, or administrative proceedings, and compliance monitoring with criminal justice entities. I understand that substance use disorder records protected by 42 CFR Part 2 may not be introduced or used in civil, criminal, administrative, or legislative proceedings without my specific written consent or a court order that complies with 42 CFR Part 2.

Information to be released, exchanged, and shared: (Please check next to the documents to be released & exchanged)

- ☐ Assessments/Intake
- ☐ Legal Records and Information
- ☐ Progress Notes/Summary
- ☐ Psychiatric/Psychological Evaluations
- ☐ Medication History
- ☐ Monthly Reports
- ☐ Treatment/Service Plans
- ☐ Discharge Summaries
- ☐ Other (Specify): _____

ACKNOWLEDGEMENTS:

I UNDERSTAND and WILLINGLY RELEASE information requested that may include information regarding the following conditions: **alcohol or drug abuse**, and/or **HIV/AIDS**. I understand that this information may include, when applicable, information relating to sexually transmitted diseases including Human Immunodeficiency Virus (HIV Infection, Acquired Immune Deficiency Syndrome, or AIDS related Complex) and any other communicable diseases. It may also include information about behavioral or mental health services, and referral and/or treatment for alcohol and drug abuse (as permitted by 42 CFR Part 2). I understand that I have the right to request a list of entities to which my records have been disclosed pursuant to this authorization, in accordance with federal law.

I UNDERSTAND that I may revoke this Authorization at any time by giving written notice to the Center, except to the extent that the Center has already taken action on this request. This authorization will expire on:

☐ Insert specific date: _____ ☐ Upon discharge from CRC ☐ Upon completion of legal proceeding or criminal justice supervision

NOTICE TO THE RECIPIENT OF THE INFORMATION

This information has been disclosed to you from records protected by federal confidentiality rules/HIPAA Privacy Regulations. These records may not be used or redisclosed except as permitted by federal law or as otherwise permitted by 42 CFR Part 2 or 45 CFR Part 164. A general authorization of the release of medical or other information is NOT sufficient for this purpose. Unauthorized redisclosure of this information is prohibited. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient and prohibits discrimination against individuals on the basis of information disclosed pursuant to 42 CFR Part 2.

AUTHORIZATION: I understand that authorizing the disclosure of this information is voluntary and will not affect my ability to receive treatment for refusal to sign. Refusal may limit the Center's ability to share information as requested above. I understand that when information is released, it carries with it the potential for unauthorized re-disclosure, and it may no longer be protected by federal confidentiality rules such as HIPAA. A copy or facsimile of this Authorization may be used with the same effectiveness as the original. I have received or been offered a copy of this release.

_____ _____

Signature of Consumer OR PERSON AUTHORIZED TO SIGN FOR CONSUMER **Date**

_____

Print name (if not the Consumer) *and* state how authorized to sign