Consent For The Release of Confidential Information

I, ____, authorize
(name of patient / client / consumer)

____
(Name of program / individual / agency making disclosure)

to disclose to ____
(name of person or organization to which disclosure is to be made)

the following information: ____
(nature and amount of information to be disclosed, as limited as possible)

____

____

The purpose of the disclosure authorized in this consent is to:

____
(purpose of disclosure, as specific as possible)

____

I understand that my treatment records are protected under state and federal regulations governing confidentiality of patient records, including the Federal Law of Confidentiality for Alcohol and Drug Abuse Patients, (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 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. I understand that any notice to revoke this consent must be in writing and that in any event, this consent expires automatically as follows:

____
(specification of the date, event, or condition upon which this consent expires)

I understand that generally ____
(name of the program)
may not condition my treatment on whether I sign a consent form, but in certain limited circumstances I may be denied treatment if I do not sign a consent form.

Dated: ____________________

______________________________ ______________________________
Signature of patient

Signature of parent, guardian,
or authorized representative
(when required)

Consent For The Release of Confidential Information
Process / Psychotherapy Notes

I, ____, authorize
(name of patient)

____
(Name of program / individual / agency making disclosure)

to disclose to ____
(name of person or organization to which disclosure is to be made)

the following information: **Process / Psychotherapy Notes**

I have been counseled by the staff of the agency and informed that a separate authorization for psychotherapy notes is necessary. I further understand that they contain the content of conversations during private counseling sessions, group therapy sessions, and/or joint or family counseling sessions.

The purpose of the disclosure authorized in this consent is to:

____
(purpose of disclosure, as specific as possible)

____

I also understand that my treatment records are protected under state and federal regulations governing confidentiality of patient records, including the Federal law of Confidentiality for Alcohol and Drug Abuse patients (42 C.F.R., Part 2) and the Health Insurance Portability and Accountability Act of 1996, ('HIPAA', 45 C.F.R., Parts 160 & 164) 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. I understand that any notice to revoke this consent must be in writing and that in any event, this consent expires automatically as follows:

____
(specification of the date, event, or condition upon which this consent expires)

I understand that generally ____
(name of the program)
may not condition my treatment on whether I sign a consent form, but in certain limited circumstances I may be denied treatment if I do not sign a consent form.

Dated: ____________________

______________________________	______________________________
Signature of patient	Signature of parent, guardian, or authorized representative (when required)

Re-disclosure Statement: **Must accompany all signed consent forms**

Prohibition on Re-disclosure of Confidential Information

This statement accompanies a disclosure of confidential health care information concerning a person and made to you with the consent of the person named.

State and federal laws, including The Health Insurance Portability and Accountability Act of 1996, HIPAA, 45 C.F.R., Parts 160 and 164, and the Federal Law of Confidentiality for Alcohol and Drug Abuse Patients, 42 C.F.R., Part 2, protects the privacy of health care information and requires patient consent prior to disclosing protected information.

The **state and 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 state law, 45 C.F.R. Parts 160 and 164 or 42 C.F.R, Part 2. **A general authorization** for the release of medical information **is not sufficient for this purpose**.

The state and federal rules restrict any use of the information to criminally investigate or prosecute any patient.