Consent for Release of Confidential Information

I, _____, whose date of birth is _____

authorize Lifeback to disclose to and/or obtain from: _____

_____

the following information: (*patient should initial each item to be disclosed*)

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Presence/Participation in Treatment
_____ Psychotherapy Notes (Cannot be combined with any other disclosure)

_____Nursing/Medical Information
_____ Toxicological Reports/Drug Screens
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____Other_____
_____Other_____

Purpose:
The purpose for this disclosure of information is to:
Coordinate care with other treatment provider(s) [ ]
Satisfy employment requirements [ ]
Satisfy legal requirements [ ]
Satisfy school requirements [ ]
Other [ ] Specify: _____

_____

_____

Marketing:

□ If the purpose of this disclosure is for marketing purposes, please check this box and set forth the financial remuneration amount received by Lifeback in exchange for disclosing the information. $_____

Sale of Information:

□ If the purpose of this disclosure is for the sale, license to use or lease of the information, please check this box.

Research:

□ If the purpose of this disclosure is for research purposes, please check this box and identify the current and future research studies as well as whether each research study is conditioned upon execution of this authorization and individual's ability to opt into each study.

_____

Revocation:
I understand that I have a right to revoke this authorization at any time by providing written notification to the Clinical Director of Lifeback. 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.

Expiration:
Unless sooner revoked, this authorization expires on _____

Conditions:
I further understand that Lifeback 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 the following consequences:

_____

_____

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

Redisclosure:
I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

Federal law 42 C.F.R. Part 2 prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R Part 2.

I will be given a copy of this authorization for my records.

_____

Signature of Patient/Client Date

_____

Signature of Witness Date

_____

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.):

_____

_____