CTC Form 2020

crossroads treatment centers

AUTHORIZATION AND CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION RELATED TO A SUBSTANCE USE DISORDER

Patient Name: _____ Date of Birth: _____

Patient ID Number: _____ Last 4 digits of SSN: _____

Crossroads Treatment Centers Clinic Name: _____

Authorization for Use/Disclosure of Information: I voluntarily consent to and authorize my above listed Crossroads Treatment Centers health care provider to disclose my health information during the term of this Authorization to the recipient(s) identified below.

Recipient: I _____ (please print first and last name) authorize my health care information to be released to the following recipient(s):

Individual or Entity Name: _____

If entity, title of the individual designated to receive the information: _____

Individual or Entity Address: _____

Individual or Entity Phone Number: _____

Purpose for Disclosure: I authorize the release of my health information, which I expressly acknowledge includes the release of my drug and alcohol treatment information for the following specific purpose (if released related to a court order, include name of court and court order number/case number):

_____

Information to be Disclosed: I understand that the information that I authorize to be disclosed is protected by federal confidentiality rules (including 42 C.F.R. Part 2 and HIPAA). The federal rules prohibit Crossroads Treatment Centers from making any further disclosure of this information unless further disclosure is expressly permitted by my written consent or as otherwise permitted by federal confidentiality rules.

I understand that a general authorization for the release of medical or other information is NOT sufficient to allow Crossroads Treatment Centers to disclose my health information including drug and alcohol treatment notes.

I understand that the federal confidentiality rules restrict any use of my health information that includes drug and alcohol treatment notes to criminally investigate or prosecute me as an alcohol or drug abuse patient.

I understand that certain HIV-related information is protected by federal and state law. Federal and state law prohibits further disclosures of this HIV-related information unless further disclosure is expressly permitted by my written consent or is authorized by the federal Confidentiality of HIV-Related Information Act.

I authorize the release of the following health information: (check all applicable boxes below)

☐ All of my health information **including drug and alcohol treatment notes** by Crossroads Treatment Center providers, that the provider has in his or her possession, including information relating to any medical history or physical condition and any treatment received by me. This does **NOT** include toxicology reports, mental health (therapy) information, or lab (blood testing) reports.

☐ All toxicology (urine or oral swabs) reports ordered by Crossroads Treatment Center providers.

☐ All lab (blood test) results-**This may include HIV/AIDS and other sensitive results.**

☐ Coordination of Care Information-this includes identifying information, participation in treatment, medications prescribed, needs for continuing treatment, appointment(s) attended and scheduled, recommendations, concerns, and prognosis.

☐ Guest Dose/Transfer Information-this includes identifying information, participation in treatment, medical history, dose amount, and take-home schedule.

☐ Family Involvement Information-this includes participation in treatment information relative to session content if family is in attendance.

☐ Dual Enrollment Information-this includes identifying information, picture ID, participation in treatment, medications prescribed, appointment(s) attended and scheduled.

☐ Discharge Information-this includes discharge date and discharge summary.

☐ Drug Screen History ☐ History and Physical ☐ Treatment Plan

☐ Participation in Treatment ☐ Intake Assessment ☐ Physician's Orders

☐ HIV/AIDS Related Information

☐ Only the following records or types of health information (must be specific, including dates that can be released):

_____

Dates of Information to be Disclosed: _____ to _____

Term: I understand that this Authorization will remain in effect:

☐ 1 year from the date this Authorization is signed by the patient (as listed below).

☐ This is a one-time release of information; once the request is fulfilled no further information can be released to the above-named recipient(s) without a new Authorization.

Re-Disclosure of Information: I understand that my health care provider cannot guarantee that the above listed recipient(s) will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to Sign and Right to Revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at Crossroads Treatment Centers. If I change my mind, I understand that I can revoke this authorization at any time by providing a written notice of revocation to Crossroads Treatment Centers at the facility/Center in which I receive my care. The revocation will be effective immediately upon Crossroads Treatment Centers' receipt of my written notice, except that the revocation will not have any effect on any action taken by Crossroads Treatment Centers in reliance on this Authorization before it received my written notice of revocation.

Additional Patient Rights: I understand that I can ask for a copy of this Authorization. I also understand that I can inspect or obtain a copy of the information I am authorizing to be released. **I understand that my records are protected under the federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I understand that if my treating provider discloses my substance use disorder treatment records pursuant to this consent, the recipient will be provided a notice of non-disclosure.**

Signature of Patient or Legal Representative/Guardian: _____

Name (printed): _____ Date: _____

Authority/Relationship of Representative to Patient: _____

Name of Witness: _____

Signature of Witness: _____ Date: _____

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NOTICE TO ACCOMPANY DISCLOSURE OF SUBSTANCE USE DISORDER INFORMATION

PROHIBITION ON RE-DISCLOSURE

This record which has been disclosed to you is protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see 42 C.F.R. § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at 42 C.F.R. §§ 2.12(c)(5) and 2.65.