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CONSENT TO RELEASE CONFIDENTIAL INFORMATION

___________________ _____ ___________

Client/Patient Name (first middle last) DOB ID or Case number

By signing this Consent for Release of Confidential Information, I authorize Catherine MacLennan PhD (and MacLennan & Peirson Psychological Services), and

Name	
Institution	
Fax number	

To communicate and disclose to one another the following confidential information

Nature and amount of information to be disclosed, as limited as possible	Medical records, progress & followup notes, diagnosis, treatment recommendations. Psychological Evaluation and Report, assessments, diagnostic summaries, testing tools and results, physical results, Facility Admission Information, Urinalysis Results, and Discharge Summary & Intake packets

The purpose of the disclosure authorized in this consent is to (as specific as possible)	Provide information as needed for psychological assessment and evaluation. Coordinate Behavioral Health Care and Medical Care.

I understand my behavioral health treatment records are protected under the Federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR, Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

<u>One year from date of signature</u>

Specification of the date, event, or condition upon which this consent expires

- This consent automatically expires upon the date of discharge from the agency regardless of the date or event referenced above.
- I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or healthcare operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.
- I understand I will be provided a copy of this form upon request.
- I understand that I have a right to receive a list of entities to which my patient-identifying Part 2 information has been disclosure pursuant to a general designation. This request must be made in writing.

Client /Patient signature	
Date	

Signature of person signing if not the client	
Date	
Describe authority to sign on behalf of client	

NOTICE OF PROHIBITION OF REDISCLOSURE OF CONFIDENTIAL INFORMATION

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.

Completed by: ______________________