adapt

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I understand that ADAPT programs will use and disclose health information about me. Adapt programs includes Crossroads Residential, Adult and Youth Outpatient, South River Community Health Center, Deer Creek Residential and Adapt Corrections.

Adapt staff members may release information about me to other Adapt staff members that concerns substance abuse, HIV, genetic testing, sickle cell information, and mental health information. This information will be disclosed on a need-to-know basis as it relates to your care. This includes clinical and administrative processes.

Name of Patient: _____

FROM / TO	**TO / FROM:**	
ADAPT Programs – The Crossroads		
3099 Diamond Lake Blvd	(Facility/Person)	_____
P.O. Box 1121	(Address)	_____
Roseburg, OR 97470	(City, State & Zip Code)	_____
(541) 672-2691 / 672-8072 fax	(Phone/Fax)	_____

Purpose of disclosure: _____

(Describe each purpose of disclosure or state "at the request of the individual" if this authorization is initiated by the individual and the individual does not, or elects not to, provide a statement of purpose.)

____ Alcohol/Drug Evaluation ____ Summary of Progress ____ Treatment Discharge Summary

____ Appointment Information ____ Emergency Contact ____ UA Results/Reports

____ Attendance Reports ____ Laboratory reports ____ Other as specified:_____

Dates of service from: _____ to _____ (please note that only the most recent records will be released if not specified).

If the information to be disclosed containing any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

____ Drug/Alcohol diagnosis, treatment and/or referral ____ Mental Health information including diagnosis and medication

____ HIV/AIDS information ____ Genetic testing information ____ Sickle cell information

I understand that my alcohol and/or drug treatment 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. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by 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. This Authorization will expire on _____ (date), 1 year from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above described purpose.

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have reviewed and I understand this Authorization. By signing this Authorization, I am directing you to disclose my health information to another person or organization that may not have or obey the same obligations to protect privacy that you do under state and federal law. Therefore, the disclosure of the information specified above carries with it the potential for an unauthorized re-disclosure and loss of protection under state and federal law.

I have been provided a copy of this form.

Dated: _____ _____ _____

Signature of Patient Signature of person signing form if not patient

Describe authority to sign on behalf of patient: _____

PROHIBITION ON REDISCLOSURE OF CONFIDENTIAL INFORMATION

This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. 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 C.F.R. 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.