EFR EMPLOYEE & FAMILY RESOURCES

Authorization to Disclose and/or Obtain Confidential Information

Name: _____ Date of Birth: _____

Case #: _____

Name of Form: _____
Date: _____

[ ] Disclose written and verbal information to the individual or organization identified below
[ ] Obtain written and verbal information from the individual or organization identified below

Person and/or Organization:

Name: _____ Address: _____

Fax: _____ Email: _____

Description of Information to be Disclosed -

BY SELECTING YES TO ITEMS BELOW YOU ARE AUTHORIZING EFR TO DISCLOSE THE INDICATED ITEM TO THE PERSON AND/OR ORGANIZATION NAMED IN THIS DOCUMENT. Please initial here to acknowledge your understanding of information be disclosed: [ ]

Yes __Assessment
Yes ____Diagnosis
No ____Psychosocial Evaluation
No ____Treatment Plan or Summary
Yes __Current Treatment Update
Yes __Presence/ Participation In Treatment
No __Medical Treatment
Yes ____Discharge/Transfer Summary
Yes ____Continuing Care Plan
Yes ____Progress in Treatment
Yes __Demographic Information
No __Psychotherapy Notes
No __Other_____
No __Other_____

Specific authorization for release of information protected by Federal and State law (client initials required):

[ ] Medical Records [X] Substance Abuse Records [ ] [ ] HIV Related Information

Purpose of disclosure: Case consultation and coordination of care

****This authorization does not meet the criteria for the release of information for purposes of sales, marketing, or research*

Expiration: This authorization will terminate upon the earlier of twelve months from the date of this authorization, or

_____ (specific date, event, or condition)

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying EFR in writing at the address provided on this form; the revocation will not apply to any information already released by EFR before receiving the revocation
- Signing this authorization is not a condition for my treatment or payment of my treatment; potential consequences for my refusal to sign this authorization, if applicable were explained to be: _____
- There is the potential that the protected health information (PHI) disclosed by EFR per this authorization may be redisclosed by the recipient and the PHI will no longer be protected by the HIPAA privacy regulations or 42CFR, Part 2 unless the recipient of the information is also obligated to and compliant with HIPAA and 42CFR, Part 2.

X _____ _____
Signature of Client Date

_____ _____ _____
Name & Signature of Person authorized to sign in lieu of the client, if applicable Date

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Explanation of representative's authority to act for the client _____

[ ] I was offered and/or given a copy of this authorization (Client and or representative initial)

NOTICE OF REDISCLOSURE

This authorization permitted information to be disclosed to you from records protected by state and federal confidentiality rules (HIPAA, 42CFR, Part 2, & Iowa chapter 228). Federal law prohibits 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 law. 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 client.