

Authorization to Disclose/Obtain Confidential Information for Treatment, Payment, and Healthcare Operations

I, _____, _____, authorize Employee & Family Resources (EFR) to:

Client Name _____ Date of Birth _____

Disclose Obtain Disclose and obtain, written and verbal information with (select all that apply):

My treating providers Third-party payers People helping to operate this program

Health plans Others (specify): _____

Description of information to be disclosed/obtained (please initial next to each item to be disclosed/obtained):

Assessment Diagnosis Treatment plan or summary Progress in treatment Presence/ participation in treatment	Discharge/transfer summary Continuing care plan Demographic information Clinical notes Other (specify): _____
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This authorization is for the purpose of (select yes/no for each item):

Treatment	Payment	Healthcare Operations
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Expiration (choose one):

End of treatment	Specific date (specify): _____	Other (specify): _____
No expiration		

I have read and understand 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 of my treatment or payment for my services. However, I understand that if I refuse to authorize disclosure for the purpose of payment, I will be responsible for any associated expenses.
- Additional 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.

Signature of Client _____ Date _____

Representative authorized to sign in lieu of client/Relationship to client _____ Date _____

Notice of Redisclosure

To the extent substance abuse information has been released pursuant to this authorization, a copy of this authorization will accompany the disclosure and the recipient should note the following obligations: **42 CFR Part 2 prohibits unauthorized use or disclosure of these records.** This authorization permitted information to be disclosed to you from records protected by state and federal confidentiality rules. Federal law (42 CFR Part 2) 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.