NOTICE

PROHIBITING REDISCLOSURE

OF ALCOHOL OR DRUG TREATMENT INFORMATION

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 Code of Federal Regulations (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.

Consent for Release of Confidential Information

I, _____, authorize
(Name of Patient)

Palouse River Counseling
(Name or general designation of alcohol/drug program making disclosure)

to disclose to **Greater Columbia Behavioral Health BHO**
(Name of person or organization to which disclosure is to be made)

the following information: **Identifying information, admission date, initial clinical assessment, program specific mental health and/or substance use disorder assessment, individual service plan, service encounters, anticipated discharge date, and discharge information if applicable.**

(Nature and amount of the information to be disclosed, as limited as possible)

The purpose of the disclosure authorized in this is to: **Support coordination of care, payment, and health care operations**.

(Purpose of disclosure, as specific as possible)

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR Parts 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, and that in any event this consent expires automatically as follows:

No more than 13 Months from the date below.
(Specification of the date, event, or condition upon which this consent expires)

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 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_____