Consent for the Release of Confidential Information

Client Name: ________________________ DOB: ____________ Dates of Service: ____________

With my signature, I authorize Vitality Unlimited to disclose and/or request the following information:

____

____

[describe how much and what kind of information may be disclosed, including explicit description of any substance use disorder information to be disclosed; should be as limited as possible.]

to ____ __________________

[name of individual(s) or entity(ies) who will receive the information and location] [Phone]

for the purpose of ____

[describe the purpose of the disclosure; should be as specific as possible]

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. Unless I revoke my consent earlier, this consent will expire automatically as follows:

____

[date, event, or condition upon which consent will expire, which must be no longer than reasonably necessary to serve the purpose of this consent]

I understand that I may be denied services if I refuse to consent to 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 have been provided with a copy of this form.

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified. I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency (AIDS), or Human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. This information may be disclosed and used by the following individual and organization; I understand that I may revoke this authorization at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to insurance companies when the law provides my insurer with the right to contest a claim under my policy. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure. I have read the above forgoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_______________________________________ __________________

Client Signature Date

_______________________________________ ______________________________

Signature of person signing form if not client (Describe relationship to client)

Date Revoked: ____________________ Staff Initials ____________

Please forward all requests to the Records Office for review.

247 Bluffs Ave., Suite 101, Elko, NV 89801 Phone: 775-389-5832 Fax: 775-389-5833

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