Rivers Edge
Behavioral Health Services

Bella's House

Consent for the Release of Information under 42 C.F.R. PART 2
Confidentiality of Substance Use Disorder Client Records

I,_____**authorize** Rivers Edge Behavioral Health Services
(Name of client) (Name of provider)

Information to be disclosed I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), mental health and substance use. I authorize the release or disclosure of the substance use disorder records below:

☐ All my substance use disorder records;

or only the following specific types of records

☐Attendance ☐Toxicology Results ☐Medication(s)/dosing ☐Assessments ☐Progress in Treatment

☐Treatment plan ☐Lab results ☐Appointments ☐Diagnostic information ☐Insurance info/demographics

☐Discharge Summary ☐ Substance Use History ☐ Trauma History Summary ☐Other: _____

To: _____
(Name of person or organization to which disclosure is to be made)

Address_____

Phone: _____ Fax: _____

For (purpose of disclosure): ☐Continuity of Care ☐Coordinating Treatment ☐ Payment/benefits administration

☐ Other: _____

I understand that my substance use disorder patient records are protected under federal regulations 42 C.F.R. Part 2 - Confidentiality of Substance Use Disorder Patient Records and cannot be disclosed without my written consent. I do not need to sign this form to obtain treatment. I may revoke this consent in writing at any time. I understand that the revocation will not be effective retroactively for information disclosures that have already occurred. If not previously revoked, this consent will terminate either:

☐ in one year from the date of signature OR 90 days after discharge (whichever comes first); **OR**
☐ **upon a specific date, event, or condition as listed here:**_____
(Specific date, event or condition)

Client Signature: _____ Date: _____
If the client is a minor, only the minor can sign this consent.

_____ _____ _____
Client Name Date of Birth (MM/DD/YY) Medical Record Number

Witness Signature_____

If the individual is unable to sign due to legal incapacity, the signature of the individual's personal representative is required. Documentation of the personal representative's legal authority must be attached.

Signature of Personal Representative: _____
Print:_____ Date: _____
Legal Authority: _____

By signing below, I am revoking this Consent for the Release of Confidential Health Information.

Client Revocation: _____ **Date:** _____

NOTICE TO RECIPIENT OF INFORMATION

42 CFR part 2 prohibits unauthorized disclosure of these records.

PO Box 27 883 Main Street Springfield, ME 04487
(P) 207-738-2488 (F) 207-738-3815

Notice of Federal Requirements Regarding the Confidentiality of Substance Use Disorder Client Information

The confidentiality of substance use disorder client records maintained by this program is protected by federal law and regulations. Generally, the program may not say to a person outside the program that a client attends the program, or disclose any information identifying a client as an alcohol or drug abuser unless:

1. The client consents in writing; **or**

2. The disclosure is allowed by a court order accompanied by a subpoena; **or**

3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation; **or**

4. The patient commits or threatens to commit a crime either at the program or against any person who works for the program,

Violation of federal law and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs.

Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

The releases of information will remain active and valid for one year from the date of signature OR until 90 days after discharge (whichever comes first) OR until a specific date, event, or condition as listed on the form. There are two ways to revoke a release of information: Come in to Bella's House where you received treatment and sign the revocation, or fax in a written statement with your name, signature, date and release(s) you would like to be revoked.

(See 42 U.S.C. §290dd-2 for federal law and 42 C.F.R. Part 2 for federal regulations governing Confidentiality of Substance Use Disorder Patient Records.)