

Consent for the Release of Confidential Information

I, _____, hereby authorize Valley Hope to (please select at least one; if no option is marked, this consent may be used to release and obtain information):

- ☐ **release** substance use disorder information **to** the listed contact
☐ **obtain** information **from** the listed contact (reverse release)

Name (person or organization), relationship, and contact information:

Name: _____ Relationship: _____

Contact Information: _____

Specific type of substance use disorder information to be disclosed:

- | | | |
|--|--|--|
| ☐ Intake Patient Information Form | ☐ Diagnoses | ☐ Dates of Treatment |
| ☐ Admission Assessment | ☐ Medical Information | ☐ Referral Form |
| ☐ Treatment Plan(s) | ☐ Doctor's Orders | ☐ Progress in Treatment |
| ☐ Progress Notes | ☐ Lab Results | ☐ Financial Info/ Arrangements |
| ☐ Continuing Care Plan | ☐ TB Test Results | ☐ All My Substance Use Disorder Information |
| ☐ Discharge Summary | ☐ History and Physical | |
| ☐ Psychological Report(s) | ☐ Presence in Treatment | |
| ☐ Other: _____ | | |

The purpose and need for such disclosure:

☐ Treatment; ☐ Payment and/or Health Care Operations; ☐ Other: _____

Without expressed revocation, this consent expires on the following date, event, or condition.

If no date, event, or condition is specified, the consent expires one year following the date of signature.

I certify that I have given this consent freely and voluntarily. I understand that my substance use disorder treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 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 in writing at any time, except to the extent that action has been taken in reliance on it.

Patient Signature: _____ Date: _____

Authorized Guardian Signature: _____ Date: _____

Note to Patient

Valley Hope's treatment services to you are not contingent upon your decision to provide or withhold consent to release information. You also have the right to receive a copy of this form and to receive a listing of entities who have received information.

Office Use Only: Complete Below When/If Substance Use Disorder Information is Released

Type of Information Released	Employee Signature	Date Information Released
_____	_____	_____
_____	_____	_____
_____	_____	_____