Addictions Recovery Center

Mail, Administration & Residential ♦1003 W. Main St. ♦ Medford, OR 97501
Walk-In Clinic & Out-Patient Services ♦ 111 Genessee ♦ Medford, OR 97504
Phone (541) 779-1282 ♦ Fax (541) 779-2081

Authorization For The Release of Confidential & Protected Health Information

Client Name: _____ **Date of Birth:** _____

I am requesting that the Addictions Recovery Center exchange verbal and/or written treatment information about me with:

Company/Agency/Individual: _____
Street Address or PO Box: _____
City, State, Zip: _____

Contact Person _____

Phone _____ **Fax:** _____
Purpose of Authorization: Chemical Dependency Treatment

Information to be released:
(client to initial information to be released, or specify in "other")

____Assessment Summary
____Psychological Evaluations
____Medical Diagnosis/Treatment
____Family Program
____Attendance and Progress
____Discharge Summaries
____Probation/Parole Information
____UA Results

____Other (specify): _____

I understand that my records are protected under the Federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and that any information that identifies me as a patient in an alcohol or other drug abuse program cannot be disclosed without my written consent except in limited circumstances as provided for in these regulations.

I understand that my records are also currently protected under the Federal privacy regulations within the Health Insurance Portability and Accountability Act (HIPPA), 45 C.F.R. Parts 160 & 164. I understand that my health information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may re-disclose the information and it may no longer be protected by the HIPAA privacy law. **The Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, noted above, however, will continue to protect the confidentiality of information that identifies me as a patient in an alcohol or other drug program from re-disclosure.**

Unless otherwise limited, this authorization is valid for 12 months (one year) from the date of signature. **I understand I have the right to revoke this authorization at any time** by submitting a written statement to the Addictions Recovery Center business office, except to the extent that action has been taken in reliance on it. I understand that this cancellation will not affect any information that was already released before the time that I revoked this authorization. I further grant the Addictions Recovery Center to notify the above named person or agency of the revocation.

In any event, this authorization expires automatically one year from date of signature below.

I understand that the covered entity seeking this authorization is not conditioning treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I have read the above and I understand what this authorization means. I am satisfied with any explanations that I may have requested and received. I approve the release of the information listed above. A photocopy or a fax copy shall be as valid as the original. I have been given a copy of this release.

_____ _____
Client Signature Date

_____ _____
Signature of Witness Date

_____
Primary Counselor