THE ADDICTION CENTER OF BROOME COUNTY INC.

REVOKED ON_____Staff sign_____

CONSENT FOR RELEASE OF INFORMATION CONCERNING ALCOHOLISM/DRUG ABUSE PATIENT

PATIENT'S LAST NAME	FIRST	M.I.
CASE NO.		
FACILITY	UNIT	

INSTRUCTIONS: **GIVE A COPY OF THE FORM TO THE PATIENT!** Prepare one (1) copy for the Patient's Case Record. If this form is used for billing purposes, prepare an additional copy for the Resource and Reimbursement Agent. If this form is sent to another agency with a request for information, prepare an additional copy for the Patient's Case Record.

[DISCLOSURE] [RELEASE] WITH PATIENT'S CONSENT

EXTENT OR NATURE OF INFORMATION TO BE DISCLOSED/RELEASED

_____ Assessment findings/Diagnosis/If applicable treatment recommendations

_____ Treatment plan summary/Attendance and compliance

_____ Urinalysis results

_____ Date of discharge, discharge plan, discharge summary

PURPOSE OR NEED FOR DISCLOSURE/RELEASE
FOR COORDINATION OF CARE

NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING/RELEASING INFORMATION	NAME OR TITLE OF PERSON OR ORGANIZATION TO WHICH THE DISCLOSURE/RELEASE IS TO BE MADE
Between: Addiction Center of Broome County 30 West State Street Binghamton, NY 13901	And: United Health Services Health Home 4401 Vestal Parkway East Vestal, NY 13850 And: Addiction Center of Broome County Health Home 457 State Street Binghamton, NY 13901

I, the undersigned, have read the above and authorize the staff of the disclosing/releasing facility named to disclose/release such information as herein contained. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire six (6) months from its signing, unless a different time, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure/release is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Pts. 160 &164; and that redisclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part.

Time period, event or condition replacing period specified above:_____

NOTE: Any information released through this form will be accompanied by the form prohibition on Redisclosure of Information Concerning Alcoholism/Drug Abuse Patient (TRS-1)

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

_____ (Signature of Patient)

_____ (Signature of Parent/Guardian, when required)

_____ (Print Name of Patient)

_____ (Print Name of Parent/Guardian)

_____ (Date)

_____ (Date)