Gaudenzia, Inc.

CONFIDENTIAL RELEASE FOR HEALTH INFORMATION

I, ______________________________ authorize Gaudenzia, Inc. to release my records

Name of Client

To:____

Name of person, agency, and/or organization to which disclosure is to be made

Address: ____

Phone/Fax/Email: ____

Information to be disclosed I understand the information to be released or disclosed is specially protected information and may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), mental health and substance use. I also understand that I retain the right to inspect a record of my mental health information.

I authorize the release or disclosure of the substance use disorder records as specified below:

☐ Date of Admission and Discharge
☐ Treatment Plan
☐ Treatment Prognosis
☐ Substance Use Diagnoses
☐ Progress in Treatment
☐ Relapse into Drug or Alcohol Abuse
☐ Mental Health History
☐ Assessments
☐ Frequency in Relapse
☐ Nature of Treatment
☐ Discharge Type Successful/Unsuccessful
☐ Substance Use History
☐ Comorbidities/Other Diagnoses

The purpose of the disclosure authorized herein is:

☐ Legal Action against Gaudenzia, Inc.
☐ Legal Action against other parties
☐ Continuity of Care
☐ Payment/Benefits Administration
☐ Other (please specify)

I understand that my substance use disorder patient records are protected under the Federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 CFR Part 2, and cannot be re-disclosed without my written consent unless otherwise provided for in the regulations.

Expiration Date (required): [Specify Date MM/DD/YYYY] ____________ . I also understand that I may revoke this consent at any time, and that in any event this consent expires automatically on the Expiration Date specified here.

RELEASE FROM LIABILITY: I release and agree to hold harmless Gaudenzia, Inc. its employees and associates from any and all liability associated with the release of confidential patient information in accord with this authorization. I understand that Gaudenzia, Inc. its employees and associates cannot be held responsible for any legal actions associated with this disclosure.

I certify that this form was fully explained to me, that I have read it and that I understand its contents. I further understand that I may refuse to sign this authorization.

Print Name/Date of Birth/Last 4 digits of SSN/Signature/Date ____

Witness Name/Signature/Date ____

The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2.