State of California — Health and Human Services Agency

Department of Health Care Services
Licensing and Certification Division
MS 2600
PO Box 997413
Sacramento, CA 95899-7413

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____, authorize
(Name of client, complainant, patient)

_____
(Name or general designation of alcohol/drug program permitted to make the disclosure)

to disclose to _____the
(Name of person or organization to which the disclosure is to be made)

following information:_____
(Nature and amount of information to be disclosed, as limited as possible)
_____

The purpose of the disclosure authorized in this consent is to:

_____
(Purpose of disclosure, as specific as possible)

_____

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality of Alcohol 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, and that in any event this consent expires automatically as follows:

_____
(Specification of the date, event, or condition upon which the consent expires)
_____

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by State law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form.

Date: _____ _____
Signature of client, complainant, patient (or if minor, of individual authorized to give consent)

Describe authority to sign on behalf of client, complainant, patient _____
_____