UNIVERSAL CONSENT TO RELEASE/REDISCLOSE CONFIDENTIAL INFORMATION

Client Name: Today's Date:

Address: Phone:

Client DOB: Client SSN:

(*The Federal Privacy Act of 1974 requires that you be notified that disclosure of your social security number is voluntary. The purpose of the request for your social security number is for the identify verification.*)

I, Click or tap here to enter text.**, do hereby consent to and authorize** Click or tap here to enter text.**to share and disclose my information to the following organizations,**

Who I want my information shared with:	
☐ Choose an item.	☐ Choose an item.
☐ Choose an item.	☐ Choose an item.
☐ Choose an item.	☐ Choose an item.
☐ Choose an item.	☐ Choose an item.
☐ Choose an item.	☐ Choose an item.

It has been explained to me and I understand that my information will be shared with the above organizations to support and assist with my care. I understand the information shared with those organizations will include the following:

What information I am agreeing to share:	
☐ Attendance at Appoints - Date Range:	☐ Discharge Summary - Date Range:
☐ The type of treatment I am receiving	☐ Psychological Evaluation - Date Range:
☐ Psychiatric Inpatient Records - Date Range:	☐ Custody Agreement
☐ A brief description of my treatment progress	☐ Treatment Plan
☐ Whether I have relapsed into drug/alcohol abuse while in treatment, the frequency of use, and the substances used.	☐ Substance Use History (Including information regarding the history, status, nature, and prognosis of treatment)
	☐ Psychiatric Evaluation - Date Range:
☐ Toxicology Report	☐ Assessments - Date Range:
☐ Lab Results	☐ Medication/Dosing
☐ Diagnostic Information	☐ Trauma History Summary
☐ Insurance Information/Demographics	☐ Physical Health Information/Status - Date Range:
☐ Biopsychosocial Assessment	☐ Immunization Records
☐ Nursing Assessment	☐ HIV/AIDS/Sexually Transmitted Disease Testing/Results
☐ Hospital Medical Records - Date Range:	☐ Emergency Room Records/Reports - Date Range:
☐ Status on Probation and/or Parole Supervision/Conditions of Supervision	☐ Risk Factors/Safety Concerns
☐ Other (Specify):	

It has been explained to me and I understand that the reason for sharing this information is solely for the purposes of:

I agree to share my information for:	
☐ Coordinating Health/Treatment Efforts	☐ Recovery Support
☐ Transferring Client Care	☐ Payment/Benefits/ Coordination of funding efforts
☐ Coordination of my basic needs	☐ Healthcare Operations

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☐ Family/Support System Engagement	☐ Legal/Court System Requirements
☐ Informing a Referral Source	☐ Employer Requirements
☐ Other (Specify):	

I understand that the information being shared is protected by Federal and State Confidentiality Regulations and other applicable rules and laws, including those listed at the end of this form, and cannot be shared without my written consent. I further understand that if the organization being authorized to receive the information is not a health plan or a health care provider, the information may be redisclosed and no longer be protected by federal privacy regulations.

I understand that the information shared in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV), my behavioral or mental health services, and treatment for alcohol and drug abuse; and this information may not be redisclosed per Pennsylvania state laws and regulations and/or Federal confidentiality rules without my express written consent. A general authorization for the release of medical or other information is not sufficient for the purpose of redisclosure.

☐ I agree to the redisclosure of my information regarding HIV/AIDS, behavioral or mental health services and treatment for alcohol and drug abuse, and I understand that my agreement is voluntary.

I am aware that I have a right to see my records, ask for changes, and have a copy of my record provided to me. Additionally, I understand that I may take back and revoke my consent at any time by notifying (verbally or in writing) any participating organization. I also understand that information already shared with those organizations cannot be taken back. Information shared as part of my involvement with the criminal justice system, due to a Judge's order, or information that the DA is putting me on ARD, AND where copies of the legal order that state I must be in treatment to continue under such a disposition are in my client record, then and only then, federal regulations state that I cannot take back the consent to release drug and alcohol treatment information to the criminal justice system until after I meet the Court's requirements.

I agree the above listed organizations/facilities, their programs, services, and employees, are released from any legal responsibility of liability for disclosure of the above information to the extent indicated and authorized. I also consent and authorize to be contacted by the phone number provided (cellular or residential) by any type of voice method and by auto-dialer technology for any permissible purpose.

I do not need to sign this form to obtain treatment. I may refuse to sign this release of information form. By signing this release, I acknowledge that a signed copy of this document has been offered to me. I may remove my consent at any time. I understand that removing my consent does not mean that information already shared will be taken back. I further understand that court order drug and alcohol information may still be provided.

I agree that my protected information may be left on or delivered to: ☐ my voicemail or other messaging system, and/or
☐ With another individual (name): _____.

By signing below I agree that my information may be shared or disclosed according to the terms of this form and in compliance with the applicable laws, rules, and regulations specified at the end of this form.

_____ _____ _____ _____
Client or Personal Representative Signature Date Witness Signature Date

_____
Client or Personal Representative Printed Name

ADDITIONAL SIGNATURE PAGE AND OPTIONS FOLLOW

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THIS PORTION TO BE COMPLETED WHEN A CLIENT IS UNABLE TO GIVE WRITTEN AUTHORIZATION OR A REPRESENTATIVE IS NOT AVAILABLE

We, the undersigned, do verify that the authorization has been read to the client and that he/she expresses an understanding of the nature of the release and freely gives his/her verbal consent for the release of information.

_____ _____
Witness Signature Date

_____
Witness Signature

☐ **Client refused to sign release of information.**

_____ _____ _____ _____
Client Signature Date Witness Signature Date

_____
Client Printed Name

Expiration Date within one year of signature: Click or tap to enter a date. **Or other event or reason:** _____

I accepted a copy of this document ☐**; I declined a copy of this document** ☐

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As applicable, the release of information authorized by this form is subject to, and all organizations disclosing or receiving information in accordance with this release agree to comply with, the requirements prescribed by:

- The HIPAA Privacy Rule, 45 C.F.R. Parts 160 and 164
- 42 C.F.R. Part 2. Confidentiality of Substance Use Disorder Patient Records.
- 4 Pa. Code § 255.1, *et seq.*
- The Pennsylvania Drug and Alcohol Abuse Control Act, 71 P.S. § 1690.101, *et seq.*
- The Pennsylvania Mental Health Procedures Act, 50 P.S. § 7101, *et seq.*
- The Pennsylvania Confidentiality of HIV-Related Information Act, 35 P.S. § 7601, *et seq.*