CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____, authorize **NMSAS Recovery Center** and

_____

to communicate between each entity the following information:

- ❑ My name and other personal identifying information
- ❑ My status as a client in substance use disorder treatment
- ❑ Financial information required for payment of treatment services
- ❑ Assessment results and history
- ❑ Treatment plan and progress toward treatment goals
- ❑ Dates and times of service
- ❑ Urinalysis results
- ❑ Date of admission and discharge
- ❑ Other_____

I, understand my HIV status is specifically protected and will not be released without my permission as noted below.

I authorize the release of my HIV status._____

Signature Date

The purpose of the disclosure authorized in this consent is to enable the organization(s) or persons listed above to coordinate care and support services, monitor my treatment progress, provide assistance in discharge planning, verify services received and to assist the organizations or persons in communicating information needed to meet state and/or federal obligations.

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 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Pts 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I also understand that I may revoke this consent orally or in writing at any time except to the extent that action has already been taken in reliance on it, and that in any event this consent expires automatically as follows:

Six months following discharge from NMSAS Recovery Center treatment services

I understand that generally neither party may condition my treatment on whether or not I sign a consent form.

_____ _____

Signature of Client Date