The Atrium
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Release of Information: Drug and Alcohol Use Information and Records

I acknowledge that information to be used or disclosed as a result of this Authorization may include records that are protected by other federal and/or state laws applicable to substance abuse. **I SPECIFICALLY AUTHORIZE THE RELEASE OF CONFIDENTIAL INFORMATION RELATING TO DRUG AND/OR ALCOHOL ABUSE.**

The recipient of drug and/or alcohol abuse information disclosed as a result of this Authorization will need my further written authorization to re-disclose this information. This means that whoever receives drug and alcohol information about me from Bucks County Anxiety Center, cannot pass on this information to another party without my signed consent.

42 CFR §2.32 restricts any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

Person/Organization Authorized to receive information:

Address: _____

Phone: _____

Relationship to patient: _____

Purpose of releasing this information: _____

Signature of the Individual or the Individual's Legally Authorized Representative

Patient's Name: Date:

Patient's Signature:

Parent/Guardian Name: Date:

Parent/Guardian Signature:

I am refusing to sign: ☐ YES

Name: _____ Signature: _____

Relationship to patient: _____

I Understand and Agree to the following:

* I have the right to review the information that is being disclosed;

* I do not have to complete this authorization and my refusal will not affect my benefits unless this authorization is necessary to determine my benefits;

* The information disclosed by this authorization may be at risk for re-disclosure by the recipient and no longer protected by federal privacy laws;

* I have a right to revoke this authorization at any time by signing the Revocation of Authorization Form provided by Bucks County Anxiety Center. Revoking this authorization will not have any effect on actions that Bucks County Anxiety Center took in using the authorization on file prior to receiving notification. For your convenience, a "Revocation of Authorization" Form may be obtained from Bucks County Anxiety Center. Bucks County Anxiety Center does not accept partial revocations. If you wish to limit who Bucks County Anxiety Center can release drug and alcohol use information to, please submit a revocation form to cancel the current Drug and Alcohol Authorization Form in place and fill out a new authorization specifying the information you are authorizing for disclosure and who may receive it.

* Bucks County Anxiety Center will not receive compensation from a third party for using or disclosing this information.

* Bucks County Anxiety Center is not responsible for another party releasing a patient's drug and alcohol use information without obtaining proper consent first.

* I have the right to a copy of this form after I sign it.

I would like a copy of this form: _☐__YES Initials: _____ Date: _____

X_____ _____

Signature of the Individual or the Individual's Legally Authorized Representative Date

Print Name: _____

Relationship to the Individual/Member (place an X next to the correct relationship status)

___Self

___Legally Authorized Representative**

___Parent of Minor Child (Power of Attorney, Legal Guardian, Executor or Administrator)

** If you are signing as a Legally Authorized Representative attach a copy of the appropriate legal document(s) granting you the authority to do so.