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 USE OR ABUSE.**

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

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

I Understand and Agree to The Following:

- I have the right to review the information that is being disclosed.
- The information disclosed by this authorization may be at risk for re-disclosure by the recipient and no longer protected by federal privacy laws.

- 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 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.

- I will receive a copy of this form after I sign it.

Authorization:

I, _____,
[patient's name]

authorize_____
[name or general designation of individual or entity making the disclosure]

to disclose _____
[describe how much and what kind of information may be disclosed, including an explicit description of any substance use disorder information to be disclosed; should be as limited as possible]

to _____
[name of individual(s) who will receive the information]

for the purpose of _____.
[describe the purpose of the disclosure; should be as specific as possible]

Unless I revoke my consent earlier, this consent will expire automatically as follows:

_____.
[date, event, or condition upon which consent will expire, which must be no longer than reasonably necessary to serve the purpose of this consent]

I understand that I may be denied services if I refuse to consent to disclosure for purposes of treatment, payment, or healthcare 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: _____

Patient's Printed Name: _____

Patient's Signature: _____

Name of person signing form it not patient: _____

Signature of person signing form if not patient: _____

Describe authority to sign on behalf of patient _____

**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.

Date revoked: _____ Staff initials:_____

I am refusing to sign: _____YES

Date: _____

Name: _____

Signature: _____

Name of Name of person signing form it not patient: _____

Signature of person signing form if not patient: _____

Describe authority to sign on behalf of patient _____

**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.

To the Person, Program, or Organization Receiving This Authorization:

NOTICE PROHIBITING RE-DISCLOSURE OF SUBSTANCE USE DISORDER INFORMATION

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). 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. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

Updated June 21, 2019, by Bucks County Anxiety Center.