

SECTION II. (cont.)

I, the undersigned, understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it. To revoke this authorization I must send a written request to:

_____ at _____.

This authorization expires on _____ or **twelve (12) months** from the date of signature, if I have not provided an expiration date.

This information is being disclosed on the condition that it not be redisclosed except as authorized or permitted by applicable Federal or State laws, including the Federal Privacy Regulations. I understand that information disclosed pursuant to this authorization may, in some instances, no longer be protected by the Privacy Regulations. Redisclosure may occur in situations such as if my provider’s care is reviewed by a state or Federal agency, a court orders the disclosure of information, or if I sue my provider and my provider needs the information to defend himself/herself.

I understand that I may refuse to sign this authorization. Signing this authorization will not affect my treatment in any way or the payment for the care I receive. I also understand that I may inspect and copy any protected health information to be used or disclosed, except as otherwise limited by applicable laws.

Please check as appropriate:

() I give my authorization to release to, obtain from, and discuss with the identified health care provider(s) the following information (**select all that apply**): ____ Medical information ____ HIV status ____ Substance abuse information ____ Behavioral health information, excluding “psychotherapy notes” as defined by HIPAA

() I give my authorization to obtain from, release to, and discuss with the identified health care providers **only medication information.**

() I **do not** give my consent to release to, obtain from, or discuss with ANY health care provider ANY information. I understand that dangerous drug interactions or other adverse medical consequences could occur from my refusal to consent to any exchange of information between my health care providers. I acknowledge that I have been advised to personally provide information to my health care providers, especially about my diagnoses and prescribed medications.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION.

Patient Signature

Signature of Patient’s Authorized Representative

Date

Relationship of Authorized Representative

PROVIDER: PLEASE SEND A COPY OF THIS SIGNED FORM TO THE IDENTIFIED HEALTH CARE PROVIDER(S), PROVIDE A COPY TO THE PATIENT, AND KEEP THE ORIGINAL IN THE PATIENT’S TREATMENT RECORD.

The information disclosed to you may be from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules and state law prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains 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. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.