CONSENT AND AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

I_____, with my date of birth being_____, authorize Phoenix Programs of Florida, Inc., d/b/a ("PHOENIX HOUSE FLORIDA") to disclose to the party identified below the following information pertaining to my treatment at PHOENLX HOUSE FLORIDA.

The Individual to whom the disclosure is to be made:

Name of Individual: _____

Address: _____

Phone Number:

Relationship / Title: _____

The purpose of the disclosure authorized is to:

_____

(Must Specify Purpose of the Disclosure)

Check the appropriate boxes to specify the type of information that may be released:

- ☐ Status/Location of Client's Treatment (e.g., active, program completed)
- ☐ Admission/induction Records
- ☐ Progress Information
- ☐ Status/Location of Client's Treatment (e.g., active, program completed)
- ☐ Admission/induction Records
- ☐ Progress Information
- ☐ Drug Test Results
- ☐ Attendance Information
- ☐ All Alcohol /Drug Treatment Records
- ☐ All Medical Records (other than HIV records). Client must sign a separate form to release HIV records.
- ☐ All Psychiatric/Psychological/Psychosocial Records
- ☐ All Vocational Records
- ☐ Discharge or Termination Information

Specified Medical Records:

_____

Other Records/information (Specify):

_____

I understand that my treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996, 45 CT ^{Q}. pts 1 60 & 164, and therefore cannot be disclosed without my written consent unless otherwise provided for in the regulations, I also understand that I may revoke this consent in writing at any time except to the extent that action has already been taken in reliance upon it, and that in any event this consent expires automatically as follows:

_____

(Must specify date, event, or condition upon which this consent will expire)

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care 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 with a copy of this form.

Patient Name Printed:_____

Signature of Patient:_____

Date:_____

Signature of Person Signing Form if Not Patient:

_____

Describe Authority to Sign on Behalf of Patient:

_____