Authorization to Disclose Information – Confidential

Patient Name:_____ FIN No:_____ DOB:_____

I authorize Hazelden Connection to disclose information about me to:

Name: _____
Relationship:_____
Address:_____
City, State, Zip:_____
Telephone:_____
Alternate Telephone:_____
Facsimile:_____
❑ Primary ❑ Secondary

Name:_____
Relationship:_____
Address:_____
City, State, Zip:_____
Telephone:_____
Alternate Telephone:_____
Facsimile:_____
❑ Primary ❑ Secondary

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Relationship:_____
Address:_____
City, State, Zip:_____
Telephone:_____
Alternate Telephone:_____
Facsimile:_____
❑ Primary ❑ Secondary

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Alternate Telephone:_____
Facsimile:_____
❑ Primary ❑ Secondary

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City, State, Zip:_____
Telephone:_____
Alternate Telephone:_____
Facsimile:_____
❑ Primary ❑ Secondary

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Relationship:_____
Address:_____
City, State, Zip:_____
Telephone:_____
Alternate Telephone:_____
Facsimile:_____
❑ Primary ❑ Secondary

The purpose of this disclosure is to communicate with and disclose to one another my participation in the Hazelden Connection Program with the following information:

- Program participation dates
- Program adherence
- Drug screen results
- Monthly accountability reports
- Continuing Care Plan details
- Updates on program participation
- Updates to Ongoing Recovery Plan
- Program financial information

I understand that:

My health information is protected by federal regulations, (42 CFR Part 2, and/or HIPAA, 45 CFR) and state privacy laws, and disclosure is allowed only with my authorization except in limited circumstances described in Hazelden's Privacy Notice. I understand that I have a right to inspect and receive a copy of my treatment records that may be disclosed to others, as provided under applicable state and federal laws.

I can revoke this authorization at any time except to the extent that action has been taken in reliance on it. Hazelden's Privacy Notice outlines the procedures for revocation. This authorization will expire two (2) years from the date I sign it unless I request an earlier expiration in writing.

For disclosures other than for treatment, payment and health care operations purposes, treatment may not be conditioned on my agreement to sign an authorization (unless I am receiving care solely to create protected health information for disclosure to a third party [42 CFR Section 164.508(b)(4)(iii)].

7

Federal confidentiality regulations (42 CFR Part 2) prohibit redisclosure of information from alcohol and drug abuse patient records. However, HIPAA requires Hazelden to notify me of the potential that information disclosed pursuant to this authorization might be redisclosed by the recipient and is no longer protected by the HIPAA rules.

Participant Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____