Consent to Release Information Authorization

I hereby authorize the use or disclosure of my individually identifiable protected health information as indicated below.

A. PATIENT INFORMATION

Patient's Full Name (First, Middle, Maiden, Last)	**Social Security Number**
Driver's License or State Issued ID #	**AIS (Inmate #), PR (Probation ID #),SID (Biometric #) (Please indicate ID type)**
Sex	**Race**
Street Address	**Date of Birth**
City, State ZIP Code	**Telephone Number**

B. DISCLOSED FROM	C. DISCLOSED TO
Person(s) or organization(s) authorized to PROVIDE the information: (Check all that apply)	**Person(s) or organization(s) authorized to RECEIVE the information: (Check all that apply)**
☐ **Alabama Department of Mental Health (ADMH)**	☐ **Alabama Department of Mental Health (ADMH)**
☐ **Community Mental Health Center (select all or present radial button list)**	☐ **Community Mental Health Center (either select all or present radial button list)**
☐ **Substance Abuse Provider Under Contract with ADMH (select all or present radial button list)**	☐ **Substance Abuse Provider Under Contract with ADMH**
☐ **Alabama Board of Pardons and Paroles (ABPP)**	☐ **Alabama Board of Pardons and Paroles (ABPP)**
☐ **Alabama Department of Corrections (ADOC)**	☐ **Alabama Department of Corrections (ADOC)**
	☐ **Other (Please specify. Note: Making an entry in this box means that data may not be shared electronically via the ASSURE web portal.)**

D. INFORMATION AUTHORIZED TO BE RELEASED

Medical Health Information About You

Check all that apply	For the following dates of service (if known):
☐ All Medical Records	
☐ Lab Reports	
☐ X-Rays and Diagnostic Test Results	
☐ All Progress Notes	
☐ TB Information/Status	
☐ Other Communicable Disease(s)	
☐ Allergies	
☐ Diabetes	
☐ Disabilities	
☐ Activity Restrictions	

☐ Other (list below):

Substance abuse, and Mental Health Information About You		
If your records include any substance abuse or mental health information, you must also complete this section to allow disclosure of these records.	**Information to Disclose** (Check all that apply)	**Initial *** (An initial is required for each authorized disclosure.)
	☐ All mental and behavioral health information	
	☐ Type of professional services rendered (psychotherapy, psychiatric, addiction treatment)	
	☐ Dates on which services were performed	
	☐ Treatment plan and recommendations	
	☐ Alcohol/substance addiction treatment records	
	☐ All progress notes	
	☐ Intake/termination statements	
	☐ Psychiatric records	
	☐ Suicide watch records	
	☐ Drug testing results	
	☐ Other, please provide a description of the information to be disclosed and include the relevant dates:	

E. PURPOSE FOR DISCLOSURE(S)

This protected health information is being used or disclosed for the following purpose(s): (Select all that apply.)

- ☐ To ensure access to and continuity of medical and behavioral health care services.
- ☐ To monitor compliance with court-ordered participation in mental health and substance abuse counseling and/or treatment services.
- ☐ Other (please specify):

F. EXPIRATION OF AUTHORIZATION

Expiration:

This authorization expires on the following event, condition, or exact date (whichever comes first) as shown below:

Event: _____

Condition: _____

Exact Date: _____

Examples

Event = For example, a judge terminates the individual's placement in a program or the individual is otherwise removed from the program.

Condition = For example, the individual successfully pays all fines, fees, and restitution.

Exact Date = For example, stating "Three years from the date the individual was assigned to the program."

G. PATIENT NOTICES

Initials*	You must initial that you have read and understand each of the following patient notices.
	1. Redisclosure of Medical Information: I understand that the information used or disclosed may be subject to re-disclosure by the person(s) or organization(s) authorized to receive it, and would then no longer be protected by federal privacy regulations.
	2. Confidentiality of Substance abuse Information: I understand that if I authorize the release of substance abuse information (as authorized on this form), this information will be disclosed from records protected by federal law and regulations relating to "confidentiality of substance abuse patient records," (42 CFR Part 2, 42 U.S.C. § 290dd-2). The Federal rules prohibit the entity,

	which I have designated to receive this alcohol and/or substance abuse information, from making any further disclosure of this information unless further disclosure is expressly permitted by my written consent 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 substance abuse patient.
	3. Right to Refuse: I understand that this authorization is voluntary and that I may refuse to sign this authorization. I understand that refusal to sign this form may disqualify me from becoming eligible for community supervision. I further understand that my refusal to sign will not affect my ability to obtain treatment or payment or affect my eligibility for benefits, unless the treatment is research related.
	4. Right to Revoke (only if not in court-ordered treatment): I understand that, as part of voluntary treatment, I have the right to revoke this authorization in writing at any time by sending written notification to **[insert name of privacy contact]** at **[insert mailing address]**. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I further understand that such action may result in my termination from community supervision.
	5. Right to Change Terms of Disclosure: I understand that by completing and signing a new consent form, I may change what information may be disclosed and who may view my information.
	6. Right to Inspect/Copy: I understand that I may obtain a copy of the protected health information to be used or disclosed under this authorization upon my termination from probation.
	7. Fees for copies: Federal and state laws permit a reasonable cost-based fee to be charged for the copying of patient records (which may include cost of supplies, postage, and labor costs for making copies, whether in paper or electronic form). I may be required to pre-pay for copies; if not, then my copies may be mailed along with an invoice for copying fees.

H. SIGNATURES

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING—Note that multiple signatures and initials are required.*

Signature of Individual* (The person about whom the information relates)	**Date of Individual's Signature**	**Signature of Guardian or Patient's Personal Representative**	**Description of Authority (or Relationship) to Act for the Individual**
		Date of Guardian or Personal Representative's Signature	

A copy of this completed, signed, and dated form must be given to the Individual or other signatory.

Official Use Only		
Date Received	**Processed By**	**Log #**

Attention Recipient Entity—Prohibition on Redisclosure of Confidential Information

This notice covers the disclosure of information to you concerning a client in mental alcohol/drug treatment, made to you with the consent of such client. 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 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 substance abuse patient.