AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, ___________________________, authorize Universal Counseling Services and

____
(Name, address, and telephone number)
to use or disclose to each other the following mental health and substance abuse health care in my medical record:

Demographic information, assessment, recommendations, participation in recommended services, treatment involvement and discharge status and recommendations.

The purpose of this release:

____

PATIENT RIGHTS

I have been informed of my privacy rights. I understand that I may refuse to sign this authorization. UCS may not condition treatment, payment, enrollment, or eligibility for benefits on whether or not I sign this consent for release of information. However if my treatment here is a condition for work, probation, etc, my failure to sign this consent or my revoking this consent could result in a negative consequence with my referring source. I may also inspect or copy information used or disclosed under this authorization.

I understand that my records are protected under Federal Confidentiality Regulations and cannot be disclosed without written consent unless otherwise provided for in the regulation.

PROHIBITION OF REDISCLOSURE: This information has been disclosed to you for records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Rules prohibit you making any further disclosure of this unless disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42CFR 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.

I understand that if the person or organizations I authorize to receive and/or use my health information are *not subject* to the federal or state health information privacy laws, they might further disclose the health information, and the health information privacy laws may no longer protect it.

If the information requested includes records/information from another agency, doctor, or hospital, I _____do or _____do not wish to have that information released under this authorization as though the agency was named above. I understand this authorization is voluntary.

EXPIRATION AND REVOCATION OF AUTHORIZATION

This Consent expires one year from the date signed unless otherwise indicated (____________). I may revoke this authorization in writing. If I did, it would not effect any actions already taken by Universal Counseling Services based upon this authorization. To revoke the authorization, I must write a letter to Universal Counseling Services (UCS) stating my request. The authorization will be revoked on the date received by UCS.

CLIENT STATEMENT

I have read and understand the contents of this authorization, and I give my consent to Universal Counseling Services and ____to request and receive, use, and disclose my health information.

____ ____________________
Client's Signature Date

____ ____________________
UCS Representative/Witness Signature Date