Addictions Recovery Center
EDUCATION • TREATMENT • COUNSELING

Mail & Administration ♦ 1003 E. Main Street #104 ♦ Medford, OR 97504 ♦ Fax (541) 608-2888
Walk-In Clinic & Out-Patient Services ♦ 1025 E. Main Street ♦ Medford, OR 97504 ♦ Fax (541) 779-2081
Addiction Medicine Clinic ♦ 1025 E. Main Street ♦ Medford, OR 97504 ♦ Fax (541) 779-0577
Residential Services ♦ 16 S. Peach Street ♦ Medford, OR 97501 ♦ Fax (541) 772-0196
Fresh Start Detox & Sobering ♦ 338 N. Front Street ♦ Medford, OR 97501 ♦ Fax (541) 776-7141
Phone (541) 779-1282 ♦ www.addictionsrecovery.org

Authorization For The Release of Confidential & Protected Health Information

Client Name: _____ **Date of Birth:** _____

I, the undersigned, hereby authorize Addictions Recovery Center to exchange verbal and/or written information as designated below.

To Whom: _____

Street Address or PO Box: (not required) _____

City, State, Zip: (not required) _____

Phone: _____ **Fax:** _____

Purpose of Authorization: **COORDINATION OF CLIENT CARE**

Information to be released:
*(client must **initial each line** next to the information to be released)*

_____ Substance Use Disorder Assessment Summary
_____ Substance Use Disorder Treatment Attendance and Progress Summary
_____ Substance Use Disorder Service Conclusion Summary
_____ UA Results Summary, including results related to substance use disorder
_____ Probation/Parole Information
_____ Medical Diagnosis/Treatment
_____ Medications, including substance use disorder medications
_____ Psychological Evaluation
_____ Other (**must be specific in description**):

I understand that my records are protected under the Federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and that any information that identifies me as a patient in a substance use treatment program cannot be disclosed without my written consent except in limited circumstances as provided for in these regulations.

I understand that my records are also currently protected under the Federal privacy regulations within the Health Insurance Portability and Accountability Act (HIPPA), 45 C.F.R. Parts 160 & 164. I understand that my health information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may re-disclose the information and it may no longer be protected by the HIPAA privacy law. **The Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, noted above, however, will continue to protect the confidentiality of information that identifies me as a patient in an substance use treatment program from re-disclosure.**

Unless otherwise limited, this authorization is valid for 12 months (one year) from the date of signature. **I understand I have the right to revoke this authorization at any time** by submitting a written statement to the Addictions Recovery Center, except to the extent that action has been taken in reliance on it. I understand that this cancellation will not affect any information that was already released before the time that I revoked this authorization. I further grant Addictions Recovery Center the authority to notify the above-named person and/or agency of the revocation.

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 read the above and I am satisfied with any explanations that I may have requested and received. I approve the release of the information listed above and acknowledge that a photocopy or a fax copy of this release form shall be as valid as the original.

I acknowledge that I have received a copy of this release. _____
Client Initials

_____ _____
Client Signature Date

_____ _____
Name & Signature of Witness Date