Grant Integrated Services
General Consent for the Release of Confidential Information

Date of Birth_____

Client ID:_____

I, _____ authorize Grant Integrated
First Middle Last

Services and_____
Name of individual/organization Address Phone #

to communicate with and disclose via verbal, written, electronic/fax or audio means, my name and status as a client in behavioral health services and information relating to the following: ***(cross off any that do <u>not</u> wish to be released)***

- Mental health and substance use assessment/Intake & treatment recommendations
- Mental health and substance use individual services/treatment plan information
- Medical information, TB Results
- Attendance, progress and compliance with services
- Diagnoses
- Financial including eligibility for public funding, insurance coverage, billing, payment arrangements, compliance with payment plans
- Discharge/Transfer Summary, continuing Care Plan/ISP and recommendation
- Urinalysis/Drug Screening results
- Legal and Court requirements regarding Treatment
- Other:_____

The purpose of the disclosure authorized herein is to coordinate services, continuation of treatment, legal purposes/facilitate a court order, billing/payment, employment and referrals to meet your needs.

I understand that my records are protected under Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2, and the Health Insurance Portability and Accountability Act of 1966 ("HIPAA"), 45 CFR, Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that the specific information to be released may also include: history, diagnosis, and/or treatment of psychiatric treatment/mental illness, drug and alcohol abuse/dependence, communicable disease and sexually transmitted diseases, including human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS). I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event, this consent expires automatically as follows:

This permission will end 30 days from date of discharge <u>or</u> on _____, whichever comes first.
Date, event or condition upon which this consent expires.

I understand that I might be denied services if I refuse to consent to a disclosure for the purpose 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 a copy of this form.

_____ _____
Client's Signature Date

_____ _____ _____
Guardian Signature (if applicable) Date Witness

(For a minor, under the age of 13, parent or guardian must sign this release)

PROHIBITION ON REDISCLOSURE
"This information has been disclosed to you from records whose confidentiality is protected by federal law, federal regulations (42 CFR part 2) prohibit you from making any further disclosure of it without the specific written consent of this person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose."