# LIFELINE CONNECTIONS

## CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

**1 ▶** I, _____ Date of Birth ____/____/_____, authorize Lifeline
(FIRST NAME / MIDDLE INITIAL / LAST NAME; Mo / Day / Year)
Connections to disclose to the person(s)/entity(s) named below (in box 2) and I also authorize the person(s)/entity(s) named below (in box 2) to disclose to and communicate with Lifeline Connections:

**2 ▶**

| Person/Entity: | Relationship: | Phone: |
|---|---|---|
| | | Fax: |

| Address: | City: | State: | ZIP: |
|---|---|---|---|
| | | | |

**3** The following confidential information (select the minimum necessary to achieve purpose of disclosure):

| | | | | | |
|---|---|---|---|---|---|
| **a** | _____ INITIALS OF PATIENT | Assessment/diagnosis results and summary, including legal, chemical dependency, mental health history, crisis history, and treatment recommendation(s). | **g** | _____ INITIALS OF PATIENT | Emergency contact and information about chemical dependency, mental and physical health emergency(s) and/or crisis, including crisis plan. |
| **b** | _____ INITIALS OF PATIENT | Presence in treatment; progress/lack of progress reports; urinalysis and breath test results; prescription medication use; compliance with treatment plan, program rules and expectations, minimal participation, and attendance. | **h** | _____ INITIALS OF PATIENT | Family and/or significant other (SO) contact; presence in treatment, messages to contact the agency. |
| | | | **i** | _____ INITIALS OF PATIENT | Family and/or SO contact, presence in treatment, progress in treatment. |
| **c** | _____ INITIALS OF PATIENT | Third-party payers: presence in treatment, diagnosis, chemical dependency and mental health treatment recommendations, continued stay progress reports, discharge summary, and financial data. | **j** | _____ INITIALS OF PATIENT | Imaging reports |
| | | | **k** | _____ INITIALS OF PATIENT | Laboratory reports |
| | | | **l** | _____ INITIALS OF PATIENT | Medical history and physical examination reports |
| **d** | _____ INITIALS OF PATIENT | Re-disclosure of: | **m** | _____ INITIALS OF PATIENT | Medication records |
| | | | **n** | _____ INITIALS OF PATIENT | Psychiatric evaluation |
| **e** | _____ INITIALS OF PATIENT | Psychological testing and assessment results. | **o** | _____ INITIALS OF PATIENT | Discharge Summary |
| **f** | _____ INITIALS OF PATIENT | Other: | | | |

**4** The purpose of the disclosure authorized herein is to (may chose more than one, if indicated):

| | | | | | |
|---|---|---|---|---|---|
| **a** | ☐ Resolve legal and/or custody issues | **e** | ☐ Facilitate consultation/referral | **H** | ☐ Coordinate crisis services |
| **b** | ☐ Acquire third-party reimbursement | **f** | ☐ Facilitate mental health/evaluation | **I** | ☐ Establish state assistance |
| **c** | ☐ Coordinate placement into treatment | **g** | ☐ Facilitate medical examination/treatment | **J** | ☐ Involve family/SO in care |

**d** ☐ Other:

**5** I, the undersigned, understand that my mental health and alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, the Health Information Technology for Economic and Clinical Health (HITECH) Act and the Health Insurance Portability and Accountability Actof 1996 (HIPAA), 45 C.F.R. Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that some of the confidential information I have authorized to be disclosed will be generated and disclosed over the course of my future treatment and after the date I signed this authorization. By signing this authorization, I authorize future disclosures made in reliance on this consent and understand that it may include disclosures after my discharge from treatment. 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 on the date, event or condition below:
▶ Expiration Date: ____/____/____ ▶ Event or Condition_____
It has been explained to me, and I understand, that generally Lifeline Connections may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

**6** ▶ _____/_____/_____ (DATE INITIATED)

**8** ▶ _____ (SIGNATURE OF PATIENT AUTHORIZING THIS CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION)

**7** _____ (SIGNATURE OF WITNESS)

**9** _____
Parent/guardian signature required for minors under age of consent. Parent/guardian signature is required for all minors when parent's/guardian's insurance is being billed for services. Releases for incompetent and deceased patients must be signed by an authorized representative.

**PROHIBITION ON RE-DISCLOSURE OF CONFIDENTIAL INFORMATION**

This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in the this record or, is otherwise permitted by 42 CFR part 2. A general authorization for release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to invetigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12 (c)(5) and 2.65.49.

Individual was offered a copy

Staff Initials_____

Lifeline Connections
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