AMADOR HEALTH CENTER

RECOVERY PROJECT

999 W. Amador Ave., Annex, Suite D
Las Cruces, NM 88011
Phone: 575.395,6953 Fax: 557.652.3785

Client's Name: _____DOB_____PT #_____

CONSENT FOR THE RELEASE OF CONFIDENTIAL MEDICAL & HEALTH INFORMATION

I, _____, authorize the above named facility (AHC/ARP) to:

☐ DISCLOSE information to ☐ OBTAIN information from the following provider/entity/agent:

Name:_____
Address:_____
_____
Phone: _____ Fax: _____

Initial each category that applies for this information exchange:

_____ my name and other personal identifying information;

_____ my status as a patient in alcohol or drug treatment;

_____ initial and subsequent evaluations of my service needs;

_____ summaries of alcohol/drug and mental health history and assessment results;

_____ summary of alcohol/drug treatment and mental health services plan(s), progress (not therapy notes) and compliance, including urine drug test results and/or breathalyzer results (not HIV or STIs)

_____attendance in alcohol/drug and mental health services (groups, classes, adjunctive therapy)

_____ discharge plan(s), dates, and/or status for alcohol/drug treatment and mental health services;

_____ dates receiving naltrexone OR buprenorphine medication assisted treatment (MAT)

_____ any other diagnostic results and current medication list regarding other specialty care, primary care or urgent/emergency care at the facility listed as provider/entity/agent.

The purpose of the disclosures authorized in this consent is to enable the above parties to evaluate my need for services and to provide and coordinate those services. I understand that my 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, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that records concerning mental health services I receive are protected by federal law under HIPAA.

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:

One month following the date I stop receiving services from the alcohol and drug treatment program or on _____.

I understand that generally the alcohol and drug treatment 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.

Client Name (print): _____ Date: _____

Client Signature: _____ Witness Signature: _____