AUTHORIZATION REVOCATION SECTION

Print Name: _____

Signature: _____

Date: _____

CleanSlate Centers, The Privacy Office
244 Main Street, PO Box 32
Northampton, MA 01061
Tel: 413-584-2173, ext. 1403
Fax: 413-320-4155

AUTHORIZATION TO DISCLOSE PROTECTED PATIENT HEALTH INFORMATION

This form is used to authorize release protected patient health information. Complete all required sections (➔).

➔**Patient's Full Name:**		➔**Patient's Date of Birth:**	

➔ **Below choose on how Party A and Party B can share or exchange the Patient's Protected Patient Health Information and Personally Identifiable Information, verbal, written, or otherwise (altogether "Patient Record").**

☐ **Party A to exchange Patient Record with Party B only** *(If selected, leave Re-disclosure box blank)*	☐ **Party A to exchange Patient Record with Party B and others noted below** (*complete Redisclosure box*)
Party A Name: CleanSlate Centers **Address:** **Phone:**	**Party B Name:** **Address:** **Phone and Fax:**

➔**Patient Record | Choose the Patient Record(s) to be disclosed:**

☐	Complete Medical Record	☐	Program/Treatment Adherence: Provider Assessment
☐	Dosage Verification	☐	Urine Screens / Analyzer Summary
☐	Treatment Verification	☐	Medical Emergency Response Information
☐	Billing Information	☐	Appointment and Scheduling
☐	Accounting of Disclosures of Patient Records	☐	Mandatory Reporting for Department of Health
☐	Other - Describe the "Other" record type to be shared:		_____ _____

➔**Purpose of Patient Record | Patient Record(s) chosen above will be used for (briefly describe):**

_____

➔**Treatment Dates of Patient Record(s) (indicated above):**	**From:** _____	**To:** _____

RE-DISCLOSURE BOX

➔ **AUTHORIZATION FOR DISCLOSURE OF ALCOHOL/DRUG ABUSE TREATMENT PATIENT RECORD:**

Party B (listed above) is authorized to re-disclose my Patient Record(s) indicated above to:

_____.

If my authorization is not provided directly above, I do not authorize "Party B" (listed above) to re-disclose, exchange or share my Patient Record(s) with anyone else except as otherwise permitted or required by law.

➔ This Authorization will expire on _____, _____, 201__ (**authorization can be granted for up to 1 year from the signature date below**) or automatically **expire 30 days from signature date (if an expiration date is not specified).**

READ ➔ I understand that federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (e.g., 42 CFR Part 2, HIPAA) protect my privacy and confidentiality. I can revoke this Authorization permitting access to my Patient Record(s) at any time in writing as long as CleanSlate Centers has not already taken action in reliance on it. I recognize that the re-disclosure or any further sharing or exchange of my Patient Record(s) as shown above may occur without my written consent by someone who receives my Patient Record(s) in accordance with this Authorization that may result in a loss of my privacy protection. I know that I have right to request an accounting of the disclosures of my Patient Records. I understand also that CleanSlate Centers will not condition my treatment at CleanSlate Centers on signing this Authorization except as permitted by law. I have read, understand, and agree with this Authorization, and freely authorize the use and disclosure of my Patient Record(s) as shown above.

➔*Signature*	➔*Date*	➔*Print Name*	➔*Relationship to Patient*