AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I authorize Blue Sky Counseling to ☐ **disclose,** ☐ **obtain,** ☐ **and exchange** confidential information, including protected health information and, when applicable, substance use disorder treatment information, with the individual(s) or organization(s) identified below for the purpose(s) listed on this form.

SECTION 1 – CLIENT INFORMATION

Client Name: ____
Date of Birth: _____________________
Address: ____
Phone Number: ____

SECTION 2 – PERSON/ORGANIZATION AUTHORIZED TO RECEIVE AND EXCHANGE INFORMATION

Name/Organization: ______________________________________
Relationship/Purpose: ____________________________________
Address: ____
Phone/Fax: ____

SECTION 3 – INFORMATION TO BE RELEASED/EXCHANGED

☐ Attendance/Compliance Information
☐ Assessment/Evaluation Results
☐ Diagnosis
☐ Progress Notes/Summaries
☐ Drug/Alcohol Screen Results
☐ Medication/MOUD Information
☐ Substance Use Disorder Treatment Information (42 CFR Part 2)
☐ Other: ____
☐ Treatment Recommendations
☐ Discharge Summary
☐ DEEP Evaluation/Treatment Information
☐ Mental Health Information

SECTION 4 – PURPOSE OF RELEASE

☐ Coordination of Care
☐ Legal/Court/Probation Requirements
☐ Insurance/Payment
☐ Client Request
☐ Referral/Continuity of Care
☐ DEEP Compliance
☐ Case Management/Care Coordination
☐ Other: ____

SECTION 5 – EXPIRATION

This authorization expires one year from the date signed unless otherwise specified below.

Expiration Date/Event: ______________________________________

SECTION 6 – CLIENT RIGHTS AND UNDERSTANDINGS

- I understand that I may revoke this authorization at any time in writing except to the extent action has already been taken.
- I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on signing this authorization.
- I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient unless otherwise protected by law.
- I understand that substance use disorder treatment records are protected under federal law **(42 CFR Part 2)** and cannot generally be redisclosed without my written consent unless otherwise permitted by law.

REDISCLOSURE NOTICE

For Substance Use Disorder Treatment Records:

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

General HIPAA Notice:

Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws unless otherwise protected by law.

SECTION 7 – SIGNATURE

Client Signature: ____ Date: _______________

Printed Name: ____

If signed by personal representative:

Representative Name: ____

Relationship/Authority: _______________________________________

Signature: ____ Date: _______________