Consent to Disclosure of Drug or Alcohol Treatment Information

I,_____ , give permission and consent for California Department of Corrections and Rehabilitation (CDCR),_____County, and any provider of substance use services to exchange without restriction and share my substance abuse treatment information.

The extent of the information to be disclosed is information related to my alcohol and/or substance use referral, diagnosis, treatment and medications, urinalysis and other lab tests, my attendance, participation and termination from treatment and my cooperation and progress, or lack thereof, in the substance use treatment program(s) to which I amreferred.

I understand that this exchange of information between the agencies identified above will be used to assure I am enrolled in the appropriate substance use treatment program(s) and to monitor my progress in treatment and to conduct program evaluation and research which may assist to further develop and refine substance use programs within CDCR.

I understand that although I am signing this consent for disclosure voluntarily, if I refuse to consent to disclose my information for purposes of treatment I may be denied for MAT for SUD by_____County. My refusal to sign the form will not prevent me from receiving other medically necessary treatment or other substance use treatment.

I also understand that any disclosure made is governed by Part 2 of Title 42 of the Code of Federal Regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 C.F.R. Pts. 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. Any information released through this form will be accompanied by the notice of the Prohibition on Redisclosure of Information Concerning Alcoholism/Drug Abuse Patient, a copy of which is attached to thisform.

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. If I do not revoke it, this consent will expire automatically three years from the date I sign, below, or upon my termination or successful completion of the MAT for SUD Program, whichever is sooner.

Patient: Name (Print): _____ Signature: Date: _____

I acknowledge that I have been provided a copy of this consent form.

Witness: Name and Title (Print): _____ Signature: Date: _____

Provider: Name and Title (Print): _____ Signature: Date: _____

NOTICE TO RECIPIENTS OF SUBSTANCE ABUSE TREATMENT RECORDS

PROHIBITION ON REDISCLOSURE

This information has been disclosed to you from records protected by Federal confidentiality (42 C.F.R. Part 2). The 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 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug use patient.