**Department of Health and Human Services**

**Adult Services**

**Consent for Release of Information**

# If multiple parties and/or agencies will be receiving this information, specify each of the parties and/or agencies below.

I, , authorize

to disclose to (Provider of confidential information)

Department of Social Services (County name)

(Other: List specific agency or person(s) or relationship)

the following information:

# (Client initials each applicable category)

My name and other personal identifying information;

All medical records;

Substance abuse records, including treatment and diagnoses;

Mental health records, including treatment plans and diagnoses;

Assessments (specify type, if necessary);

Dates that services were provided;

Recommendations for treatment;

Progress notes;

Progress and compliance with treatment;

Attendance;

Date of discharge and discharge status;

Discharge plan;

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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This otherwise confidential information will be used for the following purpose(s):

# (Client initials each applicable category)

Monitor my progress or lack of progress in treatment;

Provide appropriate services and referrals for me;

Other

***For Substance Abuse Clients:*** I understand that my records are protected under the federal regulations governing [Confidentiality of Alcohol and Drug Abuse Records, 42 CFR Part 2,](http://www.healthinfolaw.org/sites/default/files/federal-law-category-files/42%20CFR%20Part%202%20Regulations.pdf#:~:text=42%20CFR%202%20Part%202%20%28%E2%80%9CPart%202%E2%80%9D%29%3A%20Confidentiality,Congress%20subsequently%20passed%20the%20Drug%20Abuse%20Prevention%2C%20Treatment%2C) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that, except for action already taken, I may revoke this consent at any time.

***For Mental Health Clients*:** I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information. I also understand that, except for action already taken, I may revoke this consent at any time.

***Protected Health Information:***

I understand that my health information is protected under the [Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. pts 160 & 164](http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/), but once this information is disclosed pursuant to this form, it may no longer be protected by HIPAA and further redisclosure may occur. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on the consent.

If I do not revoke this consent, it expires automatically as follows:

1. Upon closure of my Adult Services case;
2. One year from the date this consent is signed; whichever occurs first.

Date signed Client’s signature

Date signed Legally Responsible Person

Client has received a copy of this consent form for his/her records.