MULTIPLE PARTY AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL ALCOHOL AND DRUG ABUSE TREATMENT AND OTHER INFORMATION FOR COORDINATION WITH MENTAL HEALTH SERVICES

I,____, authorize
(Name of patient)

Didi Hirsch Mental Health Services Substance Abuse Treatment Program and Didi Hirsch Mental Health Services Adult Mental Health Services Program to communicate with and disclose to one another the following information: (Nature and amount of the information as limited as possible)

Checked boxes indicate my authorization for the information to be shared between my substance use and mental health treatment providers.

My name and other personal identifying information

My status as a patient in [alcohol and/or drug] treatment

Initial and subsequent evaluations of my service needs by the parties named above

Summaries of alcohol/drug and assessment results and history

Discharge plan(s) for alcohol/drug treatment and services

Attendance in alcohol/drug treatment and services

Date of discharge from Alcohol/drug treatment and discharge status.

Summary of alcohol/drug treatment and services plan, progress, and compliance

Other (specify):____

____

The purpose of the disclosures authorized in this consent is to: enable Didi Hirsch Mental Health Services and the above named program to evaluate my need for services from each program and to provide and coordinate these services to me:

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, 42C.F.R. Part 2. and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that records concerning mental health and other services that I receive may be protected by state law.

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 Didi Hirsch Mental Health Services or the above named party, whichever is later.

Or specify (specify earlier date if required by state law)__________________________________

Due to COVID-19 crisis and practice of social distancing, client/responsible adult is unavailable to provide physical signature. Content of this document was reviewed verbally with client/responsible adult and client's/responsible adult's consent and understanding affirmed verbally, as noted by checked box

Dated: ________________________ ____
(Signature of client)

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(Signature of parent, guardian or person authorized)