



## Consent for Release of Confidential Medical, Mental Health and Alcohol or Drug Information for CRASH Program Participation

I, \_\_\_\_\_, date of birth \_\_\_\_\_, authorize the use and disclosure of my medical, mental health, and alcohol and drug information by and among HOWARDCenter's CRASH program and my primary care physician (including his/her staff) identified below:

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I understand that the purpose for the communication and disclosure of my medical, mental health and alcohol and drug information among the CRASH program staff and my primary physician is to facilitate my participation in the CRASH program and possible treatment referrals.

The information which I authorize to be communicated and disclosed to and by the parties listed above include my name and identifying information, any medical, mental health and alcohol and drug assessments, diagnosis, treatment, progress, attendance and discharge. The means of this communication and disclosure may be written, oral, or electronic.

I understand that my alcohol and/or drug treatment records are protected under federal regulations governing the confidentiality of alcohol and/or 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. Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by law. I understand that the confidentiality of those records as well as my medical and mental health records is also protected by State law.

I further understand that I may revoke this Consent, by notifying HOWARDCenter, at any time except to the extent that action has been taken in reliance on it. If not previously revoked, this Consent will terminate one week following completion of the CRASH program.

I understand that if I want either of the parties listed above to disclose information about me to any other organization or individual, I will need to sign a separate Consent or Authorization to release my health information for each party to whom such information is to be disclosed.

I also understand that I may request restrictions on the use or disclosure of information for the purposes described in this Consent and that HOWARDCenter may or may not agree to the requested restrictions. I also understand that generally HOWARDCenter may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied services if I do not sign such a consent form.

I have read all of the above information, and I understand its contents and consent to the communication and disclosure of the confidential information identified above to the parties listed above.

\_\_\_\_\_  
Name of Client (Please Print)

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date