Authorization

I, _________________________________ [insert client's name here], whose birthdate is ____/____/____ [insert DOB] authorize TASC, Inc. to communicate with and receive from:

List one individual/organization name and address:

1. ____

The following information (which shall not include psychotherapy notes):

____Assessment	____Insurance Information
____Diagnosis	____Presence/Participation in Treatment
____Treatment Plan or Summary	____Lab Reports/Drug Screens
____Progress in Treatment	____Demographic Information
____Medications	____Discharge/Transfer Summary
____Continuity of Care Document	____Reports from Probation, Corrections or Parole
____Criminal & Conviction History	____Psychological Evaluation
____Medical Information	____Other:_________________
____Participation in Services	____HIV/AIDS related tests and services*

______*(Initial)* *SPECIAL CONSIDERATIONS FOR HIV/AIDS: I understand that an HIV antibody or AIDS test cannot be required as a condition of treatment, and an individual cannot be required to disclose or to sign an authorization for release of information concerning his or her HIV antibody test or HIV or AIDS status as a condition of treatment. I also understand that an individual who wishes to be tested for HIV antibodies shall be informed that he or she may undergo testing on an anonymous basis.

The purpose and need for the disclosure of confidential information is to communicate with the individual(s)/organization(s) listed above regarding my participation and progress in assessment, case management and treatment, unless otherwise indicated here:

____.

____.

My treatment, payment, or eligibility for benefits will generally not be conditioned upon my authorization of this disclosure. However, to ensure reimbursement for services, I understand that I may be required to authorize disclosure to my health insurer or managed care organization.

I understand that if I am involved in the criminal justice system and participation in a TASC program is a condition of the disposition of any criminal proceedings against me or a condition of my parole or other release from custody, I must maintain all necessary authorizations until this program has been successfully completed and the disposition of the proceedings have been finalized. In other circumstances, I have the right to revoke this

authorization in writing at any time by sending written notification to my treating TASC facility. I further understand that a revocation is not effective to the extent that the disclosure agreed to has been acted on, and until the revocation is received by the person otherwise authorized to disclose records and communication. If not previously revoked, this authorization expires on the following date (if not otherwise stated, this date shall be one year from the date of this authorization): _____________________.

I also understand that any disclosure of confidential information is governed by State and Federal laws and regulations pertaining to the Confidentiality of Substance Use Disorder Patient Records (42 CFR Part 2), the Health Insurance Portability and Accountability Act of 1996 (HIPAA, 45 CFR Parts 160 & 164) and/or under the Illinois Mental Health and Developmental Disabilities Confidentiality Act. Those laws and regulations prohibit recipients of this confidential information from redisclosing it.

____

Client Signature Date

____

Client's Parent/Guardian/Authorized Representative Name (please print)

____

Client's Parent/Guardian/Authorized Representative Signature (if applicable) Date

____

TASC Staff/Witness Attesting to Identity Signature Date

NOTICE TO RECEIVING AGENCY OR PERSON: This information has been disclosed to you from records protected by Federal Confidentiality of Substance Use Disorder Patient Records Rules (42 CFR Part 2), under the Health Insurance Portability and Accountability Act of 1996 (HIPAA, 45 CFR Parts 160 & 164), and/or under the Illinois Mental Health and Developmental Disabilities Confidentiality Act. These laws and rules prohibit you from making any further disclosure of this information in this record, including any information that identifies a patient as having or having had a substance use disorder, either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2 or 45 CFR Parts 160 & 164. A general authorization for the release of medical or other information is NOT sufficient for this purpose (See §2.31). The Federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided by §§ 2.12(c)(5) and 2.65.

For Internal Use:

Client Name (Last, First): ___________________________________ **Client Date of Birth:** __________________________