Treatment Alternatives for Stronger Communities

AUTHORIZATION TO RELEASE INFORMATION

CLIENT INFORMATION: _____
Client Name (Print) Client Date of Birth

I authorize Treatment Alternatives for Stronger Communities (TASC) to use and disclose my records as indicated below:

❑ **Treatment, Payment, and Health Care Operations.**
I authorize TASC to communicate with, disclose information to, and receive records and/or information from my treating providers, health plans, third-party payors, and people helping operate this program.

❑ **Individual Person(s) or Entity(s).** *(e.g., emergency contacts, collateral contacts, recovery support providers)*
I authorize TASC to communicate with, disclose information to, and receive records and/or information from the following:

Name:	Relationship:	Address:	Contact Information:

❑ **Systems Partners.** *(Only applicable to clients with criminal legal or other system involvement.)*
I authorize TASC to communicate with, disclose information to, and receive records and/or information from the following systems partners:

❑ Judge _____
❑ Probation Officer _____
❑ Sheriff's Office _____
❑ Private Attorney _____
❑ Police Department _____
❑ Other: _____

❑ Pretrial Services Office _____
❑ Assistant State's Attorney _____
❑ Parole Officer _____
❑ Public Defender _____
❑ DCFS Caseworker _____

I understand that if I am involved in the criminal legal system and participation in a TASC program is a condition of the disposition of any criminal proceedings or is a condition of parole or other release from custody, I must maintain all necessary authorizations to release information until program completion and the disposition of proceedings are finalized.

PURPOSE FOR DISCLOSURE.
The purpose for this disclosure is to communicate with the above individual(s)/entity(s) regarding your participation and progress in services with TASC, to coordinate care, and for the purpose of treatment, payment, and health care operations.
If other purpose, please specify: _____

In the event of a disclosure necessary for emergency notification, TASC will disclose that you are participating in its program.

INFORMATION TO BE DISCLOSED.
I authorize the following information to be used and/or disclosed: ❑ Complete Record *(including information below)*

❑ Assessments and Results
❑ Treatment Plan/Summary
❑ Monthly Reports
❑ Discharge/Transfer Summary

❑ Demographic Information
❑ Progress in Treatment
❑ Presence in Services/Treatment Only
❑ Other: _____

EXPIRATION AND REVOCATION.
This authorization will remain in force and effect until expiration or revocation. This authorization expires one year post discharge from TASC, or two years from the date of execution of this authorization, whichever is sooner. Unless participation in a TASC program is a condition of a criminal proceeding, parole, or other release from custody, I have the right to revoke this authorization, in writing, at any time, by signing the Revocation form. I further understand that a revocation of this authorization is not effective to the extent that action has already been taken in reliance on the authorization, and until the revocation is received by the person otherwise authorized to use and disclose records and communication.

IMPORTANT INFORMATION ABOUT THIS CONSENT.
I 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. Generally, these laws and regulations prohibit recipients of this confidential information from redisclosure. I have the right to inspect and copy the information to be disclosed and the right to be given a copy of this authorization for my records.

I understand that if I refuse to sign this authorization, the consequence will be that no information will be disclosed. For clients with TASC participation as a condition of criminal proceedings, parole, or other release from custody, refusal to sign this authorization may lead to consequences from those authorities.

When information is disclosed with the purpose of treatment, payment, and health care operations, I understand that there is potential for the records used or disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer protected by 42 CFR Part 2. I understand that my health information may be redisclosed in accordance with permissions contained in the HIPAA regulations, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against me.

SIGNATURES

Client Name (Print)	Client Date of Birth
Client Signature	Date
Parent, Guardian, or Personal Representative Name (Print)	
Parent, Guardian, or Personal Representative	Date
Staff/Witness Signature	Date

NOTICE TO RECEIVING PERSON:
42 CFR PART 2 PROHIBITS UNAUTHORIZED USE OR DISCLOSURE OF THESE RECORDS.

THIS FORM MEETS ALL REQUIREMENTS OF 42 CFR PART 2, 45 CFR PART 160 & 164 (HIPAA) AND THE ILLINOIS MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES CONFIDENTIALITY ACT.