Rimrock
Authorization for Use or Disclosure of Protected Health Information

I, _____, date of birth: _____hereby authorize Rimrock, 1231 North 29th Street, Billings, MT 59101, and the following named agency, organization and/or persons, to communicate with and disclose to one another my protected health information as indicated below:

Name of Person or Organization: _____ Relationship:_____

Organization Contact Name: _____

Address:_____

City, State, Zip:_____

Phone:_____ Fax:_____ Email:_____

INFORMATION TO BE DISCLOSED

- ☐ Treatment Status
- ☐ Family Week Participation
- ☐ Court Referral
- ☐ DUI Evaluation Report
- ☐ Progress/Compliance Reports
- ☐ Assessment/Recommendations
- ☐ Visitation
- ☐ Treatment Discharge Summary
- ☐ Progress Notes
- ☐ Medical Assessment
- ☐ Psychiatric History & Treatment Summary
- ☐ Probation/Parole History & Reports
- ☐ Employer Conference
- ☐ Return to Work Letter
- ☐ FMLA/Short-Term Disability
- ☐ Drug & Alcohol Testing
- ☐ Cost of Treatment
- ☐ Services Provided
- ☐ Entire Treatment Record
- ☐ Education Records including IEP
- ☐ Admission/Completion Letter
- ☐ Minimum necessary medical, clinical and financial information to facilitate payment
- ☐ Other (specify):_____

PURPOSE OF DISCLOSURE

- ☐ Facilitate Diagnosis/Treatment
- ☐ Coordinate Care
- ☐ Communicate with Family
- ☐ Comply with Probation/Parole Conditions
- ☐ Facilitate Utilization Review
- ☐ Facilitate Admission
- ☐ Provide Information for Legal Action
- ☐ Investigation of Child Abuse and Neglect Reports
- ☐ Provide Follow-Up Information
- ☐ Visitation
- ☐ Results of Drug & Alcohol Testing
- ☐ Other (specify):_____

I understand that my drug and/or alcohol treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and my health information is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Part 160 and 164. My information cannot be disclosed without my written authorization unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time by notifying Rimrock, except to the extent that action has been taken in reliance on it.

This authorization expires on: _____ (specify date, event, or condition upon which this authorization expires).

I understand that I might be denied services if I refuse to consent to disclosure for purposes of treatment, payment or health care operations. I will not be denied services if I refuse to consent to a disclosure for other purposes. I have read and understand this authorization and have received a copy of it.

Method of Disclosure: ☐phone ☐mail ☐email ☐fax ☐in person ☐other:_____

_____ _____
Client Signature Date Parent/Guardian Date

_____ _____
Witness Signature Date Personal Representative Date

Describe authority to sign on behalf of the client:

_____

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS
Section 2.32, Prohibition on Re-disclosure of Confidential Information

This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). **The Federal rules prohibit you from making any further disclosure of this information** unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

SUBMIT

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