

# Rimrock

## Authorization for Use or Disclosure of Protected Health Information

I, \_\_\_\_\_, date of birth: \_\_\_\_\_ hereby authorize Rimrock, 1231 North 29<sup>th</sup> 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: \_\_\_\_\_

### SUBSTANCE USE AND/OR GENERAL INFORMATION TO BE DISCLOSED

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

### PURPOSE OF DISCLOSURE

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Facilitate Diagnosis/Treatment          | <input type="checkbox"/> Facilitate Utilization Review                    | <input type="checkbox"/> Provide Follow-Up Information     |
| <input type="checkbox"/> Coordinate Care                         | <input type="checkbox"/> Facilitate Admission                             | <input type="checkbox"/> Visitation                        |
| <input type="checkbox"/> Communicate with Family                 | <input type="checkbox"/> Provide Information for Legal Action             | <input type="checkbox"/> Results of Drug & Alcohol Testing |
| <input type="checkbox"/> Comply with Probation/Parole Conditions | <input type="checkbox"/> Investigation of Child Abuse and Neglect Reports |  |
| <input type="checkbox"/> 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. If not specified, then expiration is 6 months from date of signature). \_\_\_\_\_

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.