GAUDENZIA, INC.
CONFIDENTIAL RELEASE FOR HEALTH INFORMATION

I (Name of Client), _____ (Date of Birth) _____, **Authorize Gaudenzia, Inc. to**

Release my Records to (Name of Person, Agency, or Organization) _____

Address: _____ Email / Fax / Phone #: _____
related to my treatment during the following date range: _____ to _____.

Information to be Disclosed:

☐	Screening Documentation	☐	Clinical Notes	☐	Medication List
☐	Assessment Documentation	☐	Case Management Notes	☐	Psychiatric Evaluation
☐	Date of Admission and Discharge	☐	Discharge Summary	☐	Psychiatric Notes
☐	Appointment / Attendance History	☐	Continuing Care (Aftercare) Plan	☐	On-Site Drug Screening Results
☐	Diagnoses	☐	Physical Examination	☐	Laboratory Confirmatory Results
☐	Treatment Plans	☐	Medical Notes	☐	Laboratory Blood Test Results
☐	Other (must be very specific):				

Purpose of Disclosure:

☐	Continuity / Coordination of Treatment	☐	Compliance with Legal Requirements	☐	Employment Requirements
☐	Verification of Attendance / Completion	☐	Legal Action Against Other Parties	☐	Coordination with Primary Care
☐	Social Security Disability Claim	☐	Legal Action Against Gaudenzia	☐	Confirmation of Prescriptions
☐	To Support Funding	☐	Compliance with Probation/Parole	☐	Client Request for Own Records
☐	Other (must be very specific):				

I understand that my substance use disorder treatment records are protected under federal law, including 42 CFR Part 2 and HIPAA, and any applicable state laws. My treatment records can only be used or disclosed with my written consent, except as permitted by 42 CFR Part 2, HIPAA, and applicable state law. I understand that my substance use disorder patient records cannot be re-disclosed without my written consent except as otherwise provided for in the regulations. I understand that if HIPAA covered entities and business associates receive these records for treatment, payment, and health care operations purposes, the records may be redisclosed in accordance with HIPAA, except for uses or disclosures for civil, criminal, administrative, or legislative proceedings against me. I understand that once Gaudenzia releases information as authorized by me, that Gaudenzia has no control over what the receiving party may do with that information, and cannot be held responsible for unauthorized redisclosure.

I also understand that I may revoke this consent in writing at any time, and that in any event this consent expires automatically as specified below. I may revoke consent by sending an email to medicalrequests@gaudenzia.org.

By signing below, I release and agree to hold harmless Gaudenzia, Inc., its employees, and associates from any and all liability associated with the release of confidential patient information in accordance with this authorization. I understand that Gaudenzia, Inc., its employees, and associates cannot be held responsible for any legal actions associated with this disclosure.

Expiration Date: This consent will take immediate effect and expire in 90 days or on (Specify Date) _____, whichever is sooner.

I certify that I have reviewed this form in its entirety and understand its contents. I further understand that I may refuse to sign this authorization. If I refuse, I understand that Gaudenzia will not be able to release my records.

_____	_____	_____	_____
(Client Printed Name)	(Last 4# of SSN)	(Client Signature)	(Date of Signature)

My signature above indicates acknowledgement that I have received a copy of this release.

Federal rules prohibit any further disclosure of information in this record 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.