



**Evidence Based Addiction Medicine
dba High Point Clinic
Release of Information**

Patient Name: _____ Date of birth: _____

Address: _____

Phone Number: _____ Social Security Number: _____

I request my CONFIDENTIAL information be released **from** High Point Clinic **to** _____

I request my CONFIDENTIAL information be released **to** High Point Clinic

From _____

Phone #: _____ Fax #: _____

Please release the following information:

- | | |
|---|--------------|
| ☐ Visit Notes: Time period _____ | Other: _____ |
| ☐ Discharge Summary | _____ |
| ☐ Assessments | _____ |
| ☐ Treatment Recommendations | _____ |
| ☐ Drug Screen Results | _____ |
| ☐ Blood Test Results | _____ |

This release is for the

- | |
|---|
| ☐ Coordination of treatment services |
| ☐ Family/Social Support |
| ☐ Court/Legal |
| ☐ Disability Requests |
| ☐ Other: |

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE, OR RELATE TO MENTAL HEALTH, OR DRUG, SUBSTANCE OR ALCOHOL USE, ABUSE OR DEPENDENCE.

I UNDERSTAND THAT IF I AM REQUESTING RECORDS/INFORMATION FOR RELEASE TO ME OR MY REPRESENTATIVE:

- Laws may prevent certain records from being released to the patient.
- In certain situations, records denied for release may allow the patient to obtain a review of the denial.

DRUG/ALCOHOL ABUSE TREATMENT RECORDS: I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. This rule also prohibits anyone receiving this information or record making any further disclosure unless expressly permitted by the written consent of the person to whom it pertains. 42 CFR Part 2 prohibits unauthorized use or disclosure of these records. A general authorization is not sufficient. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

MEDICAL RECORDS: I understand that this form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR parts 160 and 164, 5 U.S.C. 552 and 38 U.S.C. 5701 and 7332; and that my records are protected and cannot be disclosed without my written consent unless otherwise provided for in the regulations. Failure to furnish complete information about your medical conditions could result in improper, inaccurate, or incomplete treatment.

I hereby authorize High Point Clinic to **RELEASE and/or OBTAIN** information and/or copies of records pertaining to my medical care and treatment, including but not limited to, alcohol and drug prevention, intervention, treatment and aftercare services, mental health diagnosis, treatment and services and other medical issues. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:
_____, _____ or upon program discharge.

RELEASE: I release High Point Clinic, its employees, and agents, from any liability in connection with the use or disclosure of the information and records released to any party pursuant to this authorization.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Release of Information Revocation: I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that by signing below, I am revoking this release of information:

Patient Signature: _____ Date: _____