386 Stanley Street
Fall River, MA 02720
Tel. (508) 679-5222
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CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

NAME: _______________________________DATE OF BIRTH __________TELEPHONE # __________________

I AUTHORIZE STANLEY STREET TREATMENT AND RESOURCES TO:

DISCLOSE TO:	RECEIVE FROM:
Massachusetts Probation Service (ASU)	*Massachusetts Probation Service (ASU)*
55 Green St., Ste 100	*55 Green St., Ste 100*
Clinton, MA 01510	*Clinton, MA 01510*

(Name, address, and FAX number of organization or person you want to send your records to or where you want to receive records from)

Purpose of this authorization: *24D Monitoring / Compliance with Conditions of Probation for 24D Education*

(*Coordination of care, change provider, personal, research, litigation, disability claim, insurance company, other-please specify)*

I authorize Stanley Street Treatment and Resources to disclose or obtain information between the following treatment dates: FROM: __________________ TO: __________________ (*Limit the information to the minimum necessary*)

Documents to be released: (Please check the following options you want disclosed or write-in OTHER line)

_____History and Physical
_____Medications / Methadone Dosage
_____Lab Tests (excluding HIV testing)
_____X-Rays and Other Diagnostic Tests
__X__Discharge Summary
__X__Group Attendance
__X__Psychosocial Evaluation
__X__Diagnosis
_____Dosing History
__X__Program Enrollment
__X__Compliance in Treatment
__X__Treatment Plan

Other: UDS Test Results, if applicable

COMPLETE THIS SECTION FOR RELEASE OF PRIVILEGED RECORDS

I understand that my record may contain some highly confidential information.
By INITIALING the lines below, I am specifically authorizing its release.

Initial ______Infectious Diseases
Initial ______Behavioral Health
Initial ______Alcohol / Drug Abuse
Initial ______Genetic Testing
Initial ______ AIDS /HIV – Diagnosis – Treatment – Labs
Initial ______ Domestic Violence/Rape/Sexual Assault
Initial______Sexually Transmitted Diseases
Initial ______All privileged conditions listed

I understand I may revoke this consent at any time except to the extent that action has been taken in reliance on it. I understand that I might be denied services if I refuse to consent to a disclosure for the purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

This consent will automatically expire **90 DAYS POST DISCHARGE** or on the following date (specify the date or event) ____________

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

________________________ (*Patient Signature*)
__________ (*Date*)
________________________ (*Signature of person signing if not the patient*)

(Initial) _____ I have been offered a copy of this form.

________________________ (*Describe authority to sign on behalf of patient*)