386/400 Stanley Street
1010 South Main Street
Fall River, MA 02720
Tel. (508) 675-1054
Fax: (508) 324-7777
www.sstar.org

# CONSENT TO RELEASE OF INFORMATION

**NAME:** _____ **DATE OF BIRTH** _____

## I AUTHORIZE STANLEY STREET TREATMENT AND RESOURCES TO:

**DISCLOSE** to: _____ **RECEIVE** from: _____

_____ _____

_____ _____

*(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: _____

*(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 dates _____to _____relating to the following:

*(Limit the information to be disclosed to the **minimum necessary**. For example: the last two years or 1/1/16 to 5/16/18 or 1/1/16 to present)*

(*Please check below the conditions you authorize or write in the specific records to disclose)*

| | | |
|---|---|---|
| _____History and Physical | _____Discharge Summary | _____Dosing History |
| _____Medications / Methadone Dosage | _____Group Attendance | _____Urine Toxicology Report |
| _____Lab Tests (excluding HIV testing) | _____Psychosocial Evaluation | _____Program Enrollment / Compliance |
| _____X-Rays and Other Diagnostic Tests | _____Diagnosis | _____Treatment Plan |

OTHER _____

## 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*** _____ AIDS / HIV Testing and Results |
| ***Initial*** _____Psychiatric Records | ***Initial*** _____ Domestic Violence/Rape/Sexual Assault |
| ***Initial*** _____ Alcohol / Drug Abuse | ***Initial*** _____ Sexual Transmitted Diseases |
| ***Initial*** _____ Genetic Testing | ***Initial*** _____ All privileged conditions listed |

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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)*

_____ _____

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

***(Initial)*** _____I have been offered a copy of this form

*Revised 1/19*