THE CARTER TREATMENT CENTER

Consent for Release of Protected Health Information

I_____,_____ hereby authorize The Carter Treatment Center
(PRINT CLIENT NAME) (PRINT DATE OF BIRTH)
and its affiliates (collectively, "Facility") to disclose the information described below to:

Agency or Person: _____

Address: _____

Email: _____

Phone: _____ Fax: _____

I authorize contact and exchange of information to the person(s)/entity named above regarding the following:

_____ Full Medical / Mental Health Records
_____ Medication Management Information
_____ Lab Reports (UDS, RPR, HIV, TB)
_____ Other (Specify) _____
_____ Billing/Financial/Insurance Information
_____ Treatment Updates
_____ Legal Information

For the Purpose of:

_____ Facilitate Treatment
_____ Coordination of Care
_____ Obtain Medical Records
_____ Other (Specify) _____
_____ At My Request
_____ Facilitate Payment
_____ Meet Legal Requirements

Information will be transmitted by the following:

_____ Written _____ Verbal _____ Audio _____ Video _____ Electronic

I understand that my records are protected under the Federal Confidentiality Regulations, including but not limited to the Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2) and the Health Insurance Portability and Accountability Act (HIPPA) and cannot be disclosed without my written consent unless otherwise provided in the regulations. This consent is subject to revocation at any time by notifying the Compliance Department in writing (email: marilyn@thecartertreatmentcenter.com) except to the extent that the Facility has already taken action in reliance on it. If not previously revoked, this consent expires automatically one year from the date of the signature below.

_____ _____
Client Signature Date

_____ _____
Staff Signature Date

Prohibition on Redisclosure of Confidential Information
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 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. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see s 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at ss 2.12(c)(5) and 2.65

_____I hereby revoke this release of information

_____ _____
Client Signature Date