Child and Family Charities

New Focus Program – Emergency Consent and Consent for PCP Communication

I, (name of client)_____ hereby ☐ **consent / ☐ do not consent**

to verbal and/or written communication between Child and Family Charities and my primary care physician _____ regarding my name, demographic information, biopsychosocial assessment information, diagnostic impression, recommendations for treatment and ancillary services, medications, dates of participation, master treatment plan, treatment progress, discharge planning for the purpose of providing continuity of care.

I also hereby ☐ **consent / ☐ do not consent**

to verbal and/or written communication between Child and Family Charities and my emergency contact regarding information about a medical, mental health or other emergency for the purpose of ensuring access to health care or other assistance.

Name of Emergency Contact: _____

Relationship: _____

Address: _____

Phone: _____

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2; the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 & 164; and the Mental Health Code, Section 330.1748 of Public Act 258. I understand that my health information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may redisclose the information and It may no longer be protected by the HIPAA privacy law. The Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, noted above, however, will continue to protect the confidentiality of information that identifies me as a patient in an alcohol or other drug program from redisclosure. I also understand that I may revoke this authorization 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:

One year following the closure of client's file at designated treatment center or one year from the date of this consent, whichever comes first.

I understand that authorizing the disclosure of this health information is voluntary and that I can refuse to sign this authorization; however, my request to release information will not be fulfilled. I understand I may inspect or copy the information to be used or disclosed. I understand that the covered entity seeking this authorization is not conditioning treatment, payment, enrollment or eligibility for benefits on whether I sign the authorization.

_____ _____

(Signature of Participant) (Date)

_____ _____

(Signature of Parent Witness) (Date)

his information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.