

**TULLY HILL CHEMICAL DEPENDENCY TREATMENT CENTER
AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL HEALTH
INFORMATION**

PATIENT LABEL

I authorize Tully Hill Chemical Dependency Treatment Center, P.O. Box 1116, Tully, NY 13159 [phone number (800) 456-6114] and only the following recipient to communicate with and disclose to one another my health information, including information about alcohol/drug abuse and mental health/co-occurring disorders.

I authorize disclosure to:

Person/Organization: _____ **Relationship:** _____

Full Address: _____

Telephone Number: _____ **Fax Number:** _____

Yes No **I consent to disclosure of my HIV-related information.**

I authorize disclosure of the following information: (Initial next to the items to be released)

_____ The fact that I'm here, how I'm doing and if I've been discharged

_____ Medical records (minimum necessary for my care)

_____ Other (specify): _____

The purpose of this disclosure is for/to: (Initial next to the items that pertain):

_____ Continuity of Care

_____ Insurance/Disability/Legal Issues

_____ Keep Significant Others Involved/Informed

_____ Update Medical Records

_____ Keep Employer/School Involved

_____ Other _____

The method of disclosure may include telephone contact, mail, fax and hand delivery, unless there is a clearly written restriction here: _____

This consent shall automatically expire 12 months after my discharge from Tully Hill, unless I specify a different time period, event, or condition here (in which case such shall apply to the expiration of this authorization). Alternate time period, event, or condition: _____

All items on this form have been completed and my questions about this form have been answered. I have been provided a copy of this form if I so requested. I know that I do not have to allow release of my medical and/or HIV-related information, and that I can change my mind at any time and revoke my authorization by writing to Tully Hill or notifying a staff member.

_____ Date: _____
Patient's Signature

_____ Date: _____
Witness's Signature (parent/legal guardian signature if patient is an
unnemancipated minor)

Patient's Printed Name

Patient's Date of Birth

This disclosure is subject to state and federal laws and regulations, including, but not limited to, NYS Public Health Law Section 17, 18 and 27, 42 CFR and 45 CFR. 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 this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains 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. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.