bloom RECOVERY NETWORK

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL SUD PATIENT RECORDS

I, _____

(CLIENT NAME)

authorize Bloom Recovery Network LLC to disclose

Registration letter, *Attendance or lack of attendance, Participation (understanding of objectives, behavior/response), cooperation with the DIP program rules and expectations,* Program Completion Report, Certificate of Completion

_____

[describe how much/what kind of information may be disclosed, including an explicit description of any substance use disorder information to be disclosed; should be as limited as possible]

TO _____

(COURT, PROBATION/PAROLE OFFICER, ATTORNEY OR OTHER REFERRING AGENCY)

*Provide contact information **IF** disclosure for Attorney or other referring agency:* _____

_____

for the purpose of

informing the criminal justice agency (or other) listed above of my Driver's' Intervention Program compliance or non-compliance.

_____

[describe the purpose of the disclosure; should be as specific as possible]

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 42 CFR 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 42 CFR 2.12(c)(5) and 42 CFR 2.65.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows:

✔ There has been a formal and effective termination or revocation of my release from confinement, probation, parole, or other proceeding under which I am mandated into treatment/prevention (DIP)

OR

_____

[date, event, or condition upon which consent will expire, which must be no longer than reasonably necessary to serve the purpose of this consent]

I understand that I may be denied services if I refuse to consent to disclosure for purposes of treatment, payment, or healthcare operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form.

_____ _____

(CLIENT DATE OF BIRTH) (SIGNATURE OF PERSON SIGNING FORM **IF** NOT PATIENT)

_____ _____

(SIGNATURE OF CLIENT) (DESCRIBE AUTHORITY TO SIGN ON BEHALF OF PATIENT)

_____

(TODAY'S DATE)

OFFICE USE ONLY **Date revoked :** _____ **Staff initials :** _____