ywca OF FORT DODGE *Center for Life Empowerment*

Consent to Release/Obtain Information

I, _____, Date of Birth, _____, authorize the release of my protected health information (PHI) as indicated below between the YWCA of Fort Dodge and:

Name of Individual(s) or Treating Provider: _____ _____

Street Address:_____ City:_____ State:____ Zip:_____

Phone: _____ Fax: _____ E-Mail: _____

☐ Yes ☐ No Substance Use Disorder/ Mental Health Records **I understand that my health record contains information relating to treatment of substance use.**

I authorize the Following PHI to be Released from my health record:

To be released by YWCA: (Check Yes or No)		
☐ Yes	☐ No	My name & other personal identification information
☐ Yes	☐ No	My status as a patient in treatment
☐ Yes	☐ No	Assessment/Evaluation/ASAM Results
☐ Yes	☐ No	Summary of treatment services/progress/compliance
☐ Yes	☐ No	Alcohol and other drug use history
☐ Yes	☐ No	Drug/Alcohol screening results
☐ Yes	☐ No	Attendance in treatment services
☐ Yes	☐ No	Discharge summary/ Information
☐ Yes	☐ No	Critical Incident Report
☐ Yes	☐ No	Other (Specify):_____

Purpose of the Disclosure (Select all that Apply):

☐ Insurance ☐ Legal ☐ Personal ☐ Coordination of Treatment Services ☐ Fundraising ☐ Billing ☐ Treatment Planning

☐ Emergency Contact ☐ Other (Specify) :_____

By signing this consent form, I understand that:

- I have the right to receive a copy of this consent and have been offered a copy. It has been presented in language I can understand.
- My treatment records can only be used or disclosed with my written consent, except as permitted by 42 CFR Part 2, HIPAA and applicable state laws. I understand if HIPAA covered entities and business associates receive these records for treatment, payment and health care operation purposes, the records may be redisclosed in accordance with HIPAA, except for uses or disclosures for civil, criminal, administrative, or legislative proceedings against me. I acknowledge there is a potential for records used or disclosed pursuant to this consent to be subject to redisclosure by the recipient and no longer protected by 42 CFR Part 2 or HIPAA. Civil and criminal penalties may attach for unauthorized disclosure of substance use, mental health, gambling or HIV/AIDS information.
- I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and in any event, this consent expires **Automatically 12 months after signature date.** I understand I may revoke consent by contacting YWCA in writing requesting the release be revoked. Unless otherwise indicated, this release allows for verbal or written disclosures. Verbal disclosures made to a third party may lose 42 CFR Part 2 protection if that agency writes the information down in their record and they are not required to follow 42 CFR Part 2. A photocopy of this release shall have the same effect as the original. I understand generally YWCA may not condition my treatment on whether I sign a consent form, but in certain limited circumstances, I may be denied treatment if I do not sign a consent for release of confidential information.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date