RICHARD J. NANCE, LCSW
DIRECTOR

SUBSTANCE ABUSE PREVENTION AND
RECOVERY INDIGENT SERVICES

UTAH COUNTY DIVISION OF SUBSTANCE ABUSE

.....a Division of the Utah County Health Department

151 SOUTH UNIVERSITY AVE., SUITE 3200 ★ PROVO, UTAH 84606 ★ PHONE (801) 851-7127

PERMISSION TO SHARE CONFIDENTIAL INFORMATION

I,_____(date of birth)_____give my permission for **Utah County**

Division of Substance Abuse to disclose the following information: ***(Client Initial all that apply):***

Diagnosis	_____
Treatment recommendations,	_____
Information about my attendance or lack of attendance at treatment sessions,	_____
My cooperation with the treatment program,	_____
Drug test results,	_____
Legal involvement, and	_____
Prognosis	_____
Other (specify) _____	_____

The purpose of the disclosure authorized, in this consent is to: _____

_____

(Purpose of disclosure, be specific)

Agency information is released to: _____

Person information will be released to: _____

Phone number: _____

I understand that I may revoke this consent at any time. Otherwise, I understand that this consent will remain in effect until one year following a formal and effective termination from the services provided or authorized by Utah County Division of Substance Abuse or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated into treatment. I understand that data derived from my participation in my treatment may be used for research purposes, so long as my anonymity is maintained in accordance with federal, state and professional research standards.

I also understand that any disclosure made is bound by 42 CFR Part 2 of the Code of Federal Regulations governing confidentiality of alcohol and drug abuse client records, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 & 164 and that recipients of this information may ***not*** be redisclosed unless otherwise provided for in the regulations..

This consent is valid until: _____

(Date, event or condition upon which this consent expires)

Signature: _____ Date: _____

Signature of Parent or Guardian/Witness: _____ Date: _____

(If applicable)

NOTICE: This electronic communication may contain protected health information, the release of which is restricted by federal law. Any information about a client or clients has been disclosed to you from records protected by federal confidentiality rules governing federally-assisted drug or alcohol abuse programs (42 C.F.R., Part 2) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). 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 C.F.R, Part 2, and HIPAA. A general authorization 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 client. Any unauthorized redisclosure of the information contained in this communication may be punishable under federal statutes.