ATCNE

ADDICTION TREATMENT CENTER OF NEW ENGLAND, INC.
77 "F" WARREN STREET • BRIGHTON • MASSACHUSETTS • 02135
CLINIC (617) 254-1271
BUSINESS OFFICE (617) 254-0191

Authorization to Disclose Protected Health Information (PHI)

Name: _____ **Date of Birth:** _____
Address: _____
_____

I hereby authorize the Addiction Treatment Center of New England to (mark all that apply)**:**

☑ Obtain from ☑ Release to ☑ Verbally speak with

Agency: _____
Name: _____ **Telephone:** _____
Address: _____

The purpose of disclosure herein is specifically for:
☒ **Treatment / coordination of care** ☐ **Other:** _____

1. **Authorization:**
   a. PHI may relate to my past, present and future physical or mental health condition, and:
      1. To the extent that it includes **alcohol or drug treatment** that is also protected by 42 CFR, Part 2:
         ☒ I specifically authorize its release. ☐ I do not authorize its release.

      2. To the extent that it includes **AIDS or HIV information** that is also protected by MGL Ch. 111 70f:
         ☐ I specifically authorize its release. ☐ I do not authorize its release.

   b. I may revoke this Authorization at any time in accordance with ATCNE's Privacy Practices.

2. **Scope of Disclosure**: PHI that may be disclosed through this *Authorization* is as follows:
   ☒ PHI in verbal, written or electronic format that is limited to my: current status, treatment compliance/progress, and treatment plan/recommendations.
   ☐ Specific PHI for the time period From: _____ To: _____ that includes:
   ☒ Psychosocial Assessment ☒ Progress Notes ☒ Medical History (incl. prescriptions)
   ☒ Methadone Dosing ☒ Substance Abuse Assessment ☒ Treatment Plan
   ☒ Lab Reports ☒ Psychiatric Assessment ☒ Drug Screens
   ☒ Discharge Summary ☒ Mental Status ☒ Blood Lab reports
   ☐ Other:_____ ☐ Other:_____

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R Part 2, and the Health Insurance Portability and Accountability Act of 1996 ('HIPAA'), 45 C.F.R. Parts 160 &164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I understand that the Addiction Treatment Center of New England cannot guarantee that the Recipient will not redisclose my alcohol and/or drug treatment information to a third party. I also understand that I may revoke this consent in writing 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 on its designated expiration date.

I understand that generally the Addiction Treatment Center of New England may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

_____

Patient's Signature: **Witness's Signature:**

Date: _____
Date of Expiration: _____one year from date of signature_____