Luminis Health℠

Pathways
RELEASE OF INFORMATION

PATIENT ID LABEL

The purpose or need for this information is to assist the staff in my rehabilitation efforts. I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent 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 according to the date listed below. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand the revocation will not apply to information that has already been released in response to this authorization. I can refuse to sign this authorization.

Patient Name: _____ Date of Birth _____

I authorize Pathways Alcohol and Drug Treatment Center to communicate with:

Person / Agency: _____

Relationship to Patient: _____ Phone _____

Address: _____

City, State, Zip Code: _____

Regarding the following confidential information: ❑ Obtain information ❑ Release information

Purposes: _____

❑ Assessment ❑ UDS Results ❑ Discharge / Continuing Care Summary
❑ Treatment History ❑ Treatment Plan ❑ Letter of _____
❑ Chemical Use History ❑ Medical History ❑ Social History/ Background

❑ Other _____

Methods for obtaining authorized information are:

❑ Verbal ❑ Written ❑ Electronic ❑ FAX _____

❑ Other *(please specify)* _____

Release of information is to remain in effect through *(date)* _____ unless revoked by me.

Patient Signature: _____ Date _____ Time _____

If you are not the patient, state legal relationship *(attach certifying documents)* _____

Staff / Witness Signature: _____ Date _____ Time _____