## LCHI Recovery Treatment

## BSAS Consent to Individual Recipient 42 CFR Part 2 And HIPAA

| Patient First Name: | Patient Last Name: | Patient DOB: |
|---|---|---|
| | | |

**Authorize LCHI to share and obtain substance abused detailed information with**

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| **(Name of Agency/ Court Department / hospital or Clinic making the disclosure)** |

**To disclose:**

| Number Treatment Sessions Attended | Assessments and Treatment Plans | Drug Tests Results | Other |
|---|---|---|---|
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For the purpose of:

| Coordinate Care for Case management<br><br>Assessment & Treatment Planning | *State agency DYS, DCF, DMH, MRC Probation or Court Involvement & Mandated Information* | *Other* |
|---|---|---|
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**I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. My consent is valid for one year from my signatures date on this form**

**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:**

| | | |
|---|---|---|
| **Print Name of Primary Contact:** | | |
| **Address:** | **Town:** | **Area code:** |
| **Phone:** | **Ext:** | **Fax:** |

****Must be signed by adult in custody if patient is under 18****

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| **Printed Patients Name:** |
| **Patients Signature:**<br>**Date Signed:** |

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| **Printed Parent/Guardian/Adult in Custody:** |