THE WEDGE MEDICAL CENTER

6701 N. BROAD STREET; 2009 S. BROAD STREET; 3609 N. BROAD STREET AND 4243 FRANKFORD AVE

CONFIDENTIAL AUTHORIZATION FORM

Drug and Alcohol Programs ***ONLY***

I, _____ , do hereby authorize The Wedge Medical Center to *RELEASE TO* _____

_____ information from the record of

_____ . Reason for this release is:_____

(Name) (D.O.B.)

AS A MEMBER IN THE WEDGE'S DRUG AND ALCOHOL PROGRAM, I UNDERSTAND THAT THE INFORMATION I AUTHORIZE TO BE RELEASE TO THE AGENCY AND / OR PERSON LISTED ABOVE IS *LIMITED TO* THE FOLLOWING: *(Only check those the apply to this Release)*

- □ **Whether or not I am attending treatment, and the frequency of my attendance**
- □ My prognosis and my diagnosis
- □ The nature of the Wedge Program I am attending
- □ A brief summary of my treatment to date
- □ A brief summary of any relapse episodes

I understand that I need not consent to the release of this information. However, I choose to do so willingly and voluntarily for the purpose(s) specified above. I have been informed of my rights (under law), and I understand the nature of this authorization to release information subject to Section III of the Mental Health Procedures Act 50 P.S. Section 7III, and the Regulations (Section 5100.31, 5100.33, 5100.34) pursuant to said Act by the Commonwealth of Pennsylvania. I also understand that my records are protected under the Federal Privacy Act (P.L. 93-575), The Federal HIPAA Administrative Simplification Provisions 45 CFR Part 160 and 164, the Federal Alcohol and Drug Abuse Act (P.L. 92-282), and the Pennsylvania Drug and Alcohol Abuse Act. I understand that it is possible that information used or disclosed pursuant to this Authorization may be redisclosed by the recipient and no longer may be subject to privacy protections provided by law. I understand that I may revoke this authorization at any time (except to the extent that action has been taken in reliance thereon.) Finally, I understand that The Wedge Medical Center may not condition my treatment on obtaining this authorization from me, except if the purpose of the treatment is to obtain information to be disclosed to a third party pursuant to the Authorization (i.e. health report that I want disclosed to an employer), or if this Authorization is for a research purpose, and treatment is involved. By my signature below, I confirm my understanding that, upon my request, if I have consented to disclose my identifying information using a general designation pursuant to 45 CFR Part 2 § 2.31(a)(4)(ii)(B) that I must be provided a list of entities to which my information has been disclosed pursuant to the general designation.

EFFECTIVE DATE OF THIS RELEASE: _____ 20_____ TO EXPIRATION DATE OF RELEASE: _____ 20 _____

_____ _____

Signature of Member Date

_____ _____

Signature of Witness Date

[ ] *I have chosen to receive a copy of this form* [ ] *I have chosen not to receive a copy of this form*

In accordance with Federal Regulations, (42 CFR Part 2 and 45 CFR Part 160 and 164) and Pennsylvania State Regulations: This information has been / is being disclosed to you from records whose confidentiality is protected by Federal and State Law. Regulations limit our / your right to make any further disclosure on this information without the prior written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information 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 patient.