SANTA FE
Recovery Center
THE PATH TO RECOVERY

CLIENT GENERAL RELEASE OF INFORMATION

Client ID#_____ Name_____ DOB_____

I, the client named above, authorize Santa Fe Recovery Center ("SFRC") to disclose to

_____
(Name of person and relationship or organization to which disclosure is to be made)

the health information identified below.

☐ Confirmation client is IN treatment facility

☐ Confirmation client has LEFT treatment facility

☐ Clinical Assessment

☐ Treatment Plan

☐ Discharge Transition Plan

☐ Medical Assessment and Records

☐ Medication Lists

☐ UA Results

☐ Other: _____

The purpose of disclosure herein is to _____
(Describe the purpose of the disclosure; should be as specific as possible)

If the person I listed above is my **Emergency Contact**, I authorize they be contacted

☐ In case of emergency

☐ In case I leave against medical/clinical advice or elope

I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 C.F.R. Part 2. and that any information that identifies me as a patient/client in an alcohol or other drug abuse program cannot be disclosed without my written consent except in limited circumstances as provided for in these regulations. I understand that my records are also currently protected under the Federal privacy regulations within the Health Insurance Portability and Accountability Act HIPAA 45 C.F.R. Parts 160 & 164. I understand that my health information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may re-disclose the information and it may no longer be protected by the HIPAA privacy law. The Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 C.F.R. Part 2. noted above, however, will continue to protect the confidentiality of information that identifies me as a patient in an alcohol or other drug program from re-disclosure.

I also understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. To revoke, I must sign a Cancellation of Client General Release of Information, while in treatment, or send a written statement to SFRC, 2504 Camino Entrada, Santa Fe, NM 87507.

This authorization expires on _____ or one year from date it was signed.
(Specify date)

For clients in the criminal justice system, when there has been a formal and effective termination or revocation of my release from confinement, probation, parole, or other proceeding in which I was mandated into treatment or specification of the date, event, or condition upon which this consent expires below.

_____
(Specification of the date, event, or condition upon which this consent expires)

I understand that the covered entity seeking this authorization will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the authorization. I understand that I am entitled to receive a copy of this authorization.

☐ I want a copy of this release.

☐ I decline a copy of this release.

Client Attestation

My signature indicates that I have understood all the statements above.

_____ _____

Client Signature Date

_____ _____

Witness Signature Date