CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION
(Doctor/Dentist)

I, ____ hereby authorize Peer Assistance Services,
(Print client's first, middle, last name)

Inc. to release the following information, concerning me, to:

____
(Name of person or organization) (Phone)

____
(Street Address) (City) (State) (Zip) (Fax)

The purpose of this disclosure is: ____.

Items and information to be disclosed are:

- ❑ Treatment records
- ❑ Testing results
- ❑ Emergency-related information
- ❑ Reports of compliant and/or non-compliant behavior
- ❑ Assessment summary and/or recommendations
- ❑ Screening tool information
- ❑ Ability to practice with reasonable skill and safety
- ❑ Other____
  (specific record or records)

The confidentiality of alcohol and drug abuse records maintained by Peer Assistance Services, Inc., is protected by Federal laws and regulations. Generally, we may not say to a person outside the program that a client involved with Peer Assistance Services, Inc., attends the program or disclose any information identifying a client as an alcohol or drug abusers—unless: 1) You consent to the disclosure of information in writing; 2) The disclosure is ordered by a court; or as otherwise mandated by State and/or Federal law; 3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. If not sooner revoked, this consent shall expire two (2) years after my discharge from Peer Assistance Services, Inc. (42 C.F.R. § 2.31).

A copy of this document will have the same force and effect as the original.

____ ______________________
Client Signature Date

PEER ASSISTANCE SERVICES, INC. Start believing.
2170 South Parker Road, Suite 229 | Denver, Colorado 80231
TEL 303.369.0039 TOLL-FREE 1.866.369.0039 FAX 303.369.0982
www.peerassist.org | www.codrugfreeworkplace.org

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Authorization for Use or Disclosure of Protected Health Information

(Doctor/Dentist)

Pursuant to 45 CFR §164.508 and the Health Insurance Portability and Accountability Act, I, ____, hereby authorize ________________________________ (name of practice) and/or his/her administrative and clinical staff to use or disclose the protected health information ("PHI") described below to the persons and for the purposes set forth below:

1. The PHI which I authorize to be used or disclosed are:

____

____

2. The entity or entities, person(s) to receive the PHI identified above are: PEER ASSISTANCE SERVICES, INC., 2170 Parker Road, Suite 229, Denver, CO 80231

3. My PHI may be used or disclosed for the following purposes: ANY

4. This authorization shall be in force and effect until either the following date or event: the later of (a) one year from the date of this agreement; or (b)____, at which time this authorization to use or disclose PHI shall expire.

5. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written revocation to the Privacy Officer at ___________________________________[name of practice]. I understand that a revocation will not be effective to the extent that [name of practice] has already used or disclosed the PHI described above in reliance on this authorization. I also understand that a revocation will not be effective if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim under the policy or the policy itself.

6. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal law.

7. I understand that _________________________________[name of practice] will not condition my treatment on whether I authorize the requested use or disclosure of PHI, except (1) if my treatment is related to research and the use or disclosure is for such research, or (2) my treatment is being provided to me solely for the purpose of creating protected health information for disclosure to a third party, and the use or disclosure is for that third party.

8. By my signature below, I acknowledge that I have received a copy of this authorization to use or disclose PHI.

Date: _______________________

____
Signature of Patient or Personal Representative

____
Authority of Personal Representative to sign

[Provide a copy of this form to the patient.]