Southeast Missouri Behavioral Health, Inc.

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

CLIENT NAME: _____ CLIENT ID #: _____

DATE OF BIRTH: _____ SS #: _____

I, _____, authorize
(Name of client)

_____
(Name of general designation of program making disclosure)

to disclose to: _____
(Name of person or organization to which disclosure is to be made)

the following information: _____

_____

The purpose of the disclosure authorized herein is to: _____

_____

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR 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 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 as follows:

_____

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

_____ _____
Signature of Participant Date Signature of Witness Date

_____
Signature of parent, guardian or Date
Authorized representative, when required

CONFIDENTIAL

This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164, prohibit you from making any further disclosure of it without the specific written consent to the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.