I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize

 **(Name of client)** **(Treatment Facility)**

to disclose to the **Bucks County Drug & Alcohol Commission**, **Inc**. the following information:

**Please check all:**

* Whether I am receiving services/treatment
* My prognosis
* Nature of the agency
* Brief description of my progress
* Whether I have relapsed into drug and/or alcohol use and frequency of relapse
* Status of my Medical Assistance application

And that the **Bucks County Drug & Alcohol Commission, Inc.,** disclose to the agency listed above the following information:

**Please check all (If other, please specify):**

* Eligibility for funding status
* Status of Medical Assistance application
* Whether I am receiving services/treatment
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This information is needed for the following reason (s) (Purpose of disclosure, as specific as possible):

**Please check all (If other, please specify):**

* Provide and coordinate case management services
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient records, section 543 of the Public Health Service Act, 42, U.S.C. 290dd-2 and its implementing regulation, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), and its implementing regulation, 45 C.F.R. Pts. 160 & 164 and, the Pennsylvania Drug and Alcohol Abuse Control Act, 71 P.S. §1690 through 1690.112 et seq., 4 Pa.Code § 255.5, as well as Act 126 42 Pa. C.S.A. § 6352.1 and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I understand that my consent is voluntary and can be withdrawn at any time through verbal or written communication with the Bucks County Drug & Alcohol Commission, Inc., 55 East Court Street, 4th floor, Doylestown, PA 18901,

215-444-2700 except when information has been disclosed prior to the date of withdrawing my consent. Unless I withdraw my consent, this consent expires automatically as follows:

**Please check one (If there is a blank line, please include date of expiration):**

* If I’m a person involved with the criminal justice system who is in treatment as a condition of the court I may not revoke consent until (specify a date/event/or condition):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ in accordance with 42 CFR Part 2 Subpart C § 2.35.
* If I’m not a person involved with the criminal justice system seeking treatment as a condition of the court, this consent will expire one year after this consent form is signed.
* Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have been offered a copy of this document and have **(please mark appropriate box):**

 [ ] Accepted [ ] Refused

 / / / /

 Signature of Client Date Signature of Witness Date