# CDL CONFIDENTIAL

**AUTHORIZATION FOR THE RELEASE OF INFORMATION**

|  |  |  |
| --- | --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Member Name | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Birthdate | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Member ID/SS # |

The undersigned authorizes United Behavioral Health to release to and obtain from:

|  |  |
| --- | --- |
| **X**\_\_\_\_\_\_\_ | CDL Program Coordinator(s) |
| **X**\_\_\_\_\_\_\_ | NIDA Certified Laboratory |
| **X**\_\_\_\_\_\_\_ | Office of Administration-SEAP Staff |
| **X**\_\_\_\_\_\_\_ | Agency and/or Field SEAP Coordinator |
| **X**\_\_\_\_\_\_\_ | Manager/Supervisor |
| **X**\_\_\_\_\_\_\_ | Labor Relations/Personnel Officer/SPF Coordinator |
| **X**\_\_\_\_\_\_\_ | Union Representative |
| **X**\_\_\_\_\_\_\_ | Treatment Provider(s) |
| **X**\_\_\_\_\_\_\_ | SEAP Evaluator/SAP |
| \_\_\_\_\_\_\_\_ | Other: Specify: \_\_\_\_\_ |
|  |  |

the following business records and information concerning Patient ("Records"):.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Attendance Only |  | Substance Dependency Assessment | |
|  | Social History |  | Psychology Report | |
|  | Treatment Plans |  | Discharge Reports/Summaries | |
|  | Consultation Report |  | All pertinent Records UBH deems appropriate for the purpose. | |
| X | Other (Describe):  Your compliance with the CDL Referral\_\_\_\_\_\_\_\_\_ | | |

This Authorization \_\_\_\_\_\_\_\_\_\_**X**\_\_\_**does** \_\_\_\_\_\_\_\_\_\_\_\_**does not** include Records created by other providers that are in UBH’s possession.

The purpose of this release is:

|  |  |
| --- | --- |
| X | To allow the clinically appropriate management and coordination of Patient’s employee assistance mental health and/or substance abuse services and/or coverage under Patient’s health benefit plan. |
|  | To allow payment by Patient’s third party payor and as necessary for or related to administration, quality improvement, utilization review and enforcement of the Patient’s health benefit plan, including, but not limited to coverage disputes and Patient’s continued eligibility. |
|  | To keep Patient’s parent(s) aware of Patient’s treatment |
|  | To allow UBH to receive payment from Patient’s credit card company. |
|  | Other (Describe): |

I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations.

I understand that my records may contain information regarding my mental health, substance use or dependency, or sexuality, and also may contain confidential HIV/AIDS – related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named above.

I also understand that my health plan may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this form, except for certain eligibility or enrollment determinations prior to my enrollment in its health plan, and for health care that is solely for the purpose of creating protected health information for disclosure to a third party.

**I understand that I may revoke this authorization at any time by notifying UBH in writing, but if I do, it will not have any effect on any actions UBH took before it received the revocation.**

**THE MEMBER OR THE MEMBER’S PERSONAL REPRESENTATIVE\* MUST READ AND SIGN THE FOLLOWING STATEMENTS:**

\* A personal representative is an individual who has the legal authority to act on behalf of another individual regarding decisions relating to health care.

**I understand that this authorization will expire**:

On       (MM/DD/YYYY) or one year from the date of the signature below (or as set forth by other applicable federal or state law)

#### OR

Once the following event occurs: after completion of a one-year follow-up period, which occurs at the conclusion of treatment

***Form must be completed before signing***

Signature of Member Date

or Member’s Personal Representative

Print Name of Member’s Description of Personal Representative’s

Personal Representative Authority to Act for Individual

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Signature of Witness Date

I understand that I am entitled to a copy of my signed authorization.

***UNDER HIPAA, YOU CANNOT BE DENIED HEALTH TREATMENT OR COVERAGE IF YOU REFUSE TO SIGN THIS AUTHORIZATION. HOWEVER, YOUR EMPLOYER IS PERMITTED UNDER HIPAA TO REQUIRE YOU TO SIGN THIS AUTHORIZATION AS A CONDITION OF YOUR EMPLOYMENT.***