January 1, 2004

To whom it may concern:

Beginning April 14, 2003 SCVMC is required to obtain an authorization, which is HIPAA compliant for its members/patient when written authorization is required to use or disclose protected health information (PHI). A HIPAA complaint authorization must comply with the requirements of the HIPAA Privacy Rule except when other applicable law imposes additional or more stringent authorization requirements. A valid HIPAA authorization has several required elements, which include specifying what information is to be released, who is to release it and receive it, why it is being release, how long the release may occur, how to revoke the permission if so desired, and signature and date of the member/patient.

Beginning January 1, 2004 SCVMC is required to obtain an authorization printed in 14 font per new regulation as of January 1, 2004 (the font size of Authorization has been changed to 14 font)

We have enclosed SCVMC HIPAA compliant authorization form for you to utilize so that we can process your requests for our members/patients. Please have the member complete the HIPAA compliant authorization, attach your request and mail back to our department for processing.

Thank you,

Medical Legal Department

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL CLIENT INFORMATION

CLIENT NAME: _____ DATE OF BIRTH:

SOCIAL SECURITY NUMBER: _____ UNI/Care ID NUMBER:

NOTICE TO RECIPIENT: Federal Regulations <u>prohibit further disclosure</u> of information without specific written consent from the person to whom the information pertains. A general authorization for release of medical or other information is NOT sufficient for this purpose.

I, _____**, hereby authorize** _____
(Please print-Client/Participant Name) (Person/Agency Name)

at _____ **to disclose records/information obtained in the**
(Telephone Number)

course of services rendered to me to:_____.
(Person/Agency Name)

The disclosure of records/information authorized herein is required for the following purpose(s):

and shall be limited to the following specific types of information (select one or more):

Clt Initials		Clt Initials	
	Demographic		Physical examination results
	Financial		Psychiatric examination results
	Assessment/intake summary		Medications (current and past)
	Dates/attendance/types of services		Correspondence
	Alcohol and other drug test results		Discharge summary
	Treatment progress		
	Continuum of care referral summary		Any information in my treatment record
	Other (specify):		

I understand that this information may be provided in person or by phone, fax, mail, and/or email.

By signing below, I am consenting to the communications as indicated above. I understand that my Alcohol and Drug treatment 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 CFR, Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. The exceptions are set forth in the Notice of Privacy Practices.

SEE NEXT PAGE- - -

CLIENT NAME: _____ DATE OF BIRTH:

SOCIAL SECURITY NUMBER: _____ UNI/Care ID NUMBER:

I also understand that I may revoke this authorization in writing at any time except to the extent that action has been taken on it by providing a copy of the written notice withdrawing my consent to the Department of Alcohol and Drug Services Privacy Officer at the address set forth in the Notice of Privacy Practices. I have received a copy of this consent. In any event this consent expires automatically as follows: _____.

(Date/event/condition upon which this consent expires).

DADS may not condition treatment, payment, enrollment or eligibility for benefits on whether the client signs this authorization except if it is for research related treatment, or, if it is used for determining enrollment in the health plan or eligibility for benefits if relating to individual or for its underwriting or risk rating determinations, and it does not provide for the use or disclosure of psychotherapy notes; or when treatment is provided for the sole purpose of providing information to third party.

_____ _____

(Client signature) (Date)

_____ _____

(Legal representative on behalf of client) (Date)

Legal authority to sign on behalf of client:

_____

_____.