DAYMARK Recovery Services

Medicaid #: _____ **MR#:_____**

Client Name:_____ **Date of Birth:_____**

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I _____ hereby authorize

(Client or Personal Representative)

DAYMARK RECOVERY SERVICES

(*Name of Provider/Plan)*

to disclose/exchange specific health information from the records of the above named client to/from

Dominion Diagnostics

211 Circuit Drive, North Kingstown, RI 02852-7440

Phone #: (401) 667-0800 Fax #: (401) 667-0330

For the specific purpose(s): **Urine Screens**

Specific information to be disclosed: **Demographics, SS#, medical record#, insurance information, medications, substance use, and diagnosis(es).**

I understand that this authorization will expire on the following date, event or condition: _____.

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the *Revocation Section* below. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from redisclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that my information is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed unless provided for under the act. In addition alcohol and drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 C.F.R Part 2 and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, communicable disease(s), alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing, this disclosure will include that information. HIV/AIDS information is only disclosed in accordance with Communicable Disease Laws (GS130A-143).

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization.

Signature of Client	*Date*	*Witness (required only when signature is 'X', mark or symbol)*	*Date*
Signature of Personal Representative	*Date*	*Personal Representative Relationship/Authority*	*Date*

REVOCATION SECTION

I do hereby request that this authorization to disclose health information be rescinded, effective _____ **(Date).** I/Client/Personal Representative **(circle one)** understand(s) that any action taken on this authorization prior to the rescinded date is legal and binding.

Signature of Client	*Date*	*Witness (required only when signature is 'X', mark or symbol)*	*Date*
Signature of Personal Representative	*Date*	*Personal Representative Relationship/Authority*	*Date*
Signature of Staff	*Date*	*Signature of Staff Witness (if verbal revocation)*	*Date*