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DIRECTOR



SUBSTANCE ABUSE PREVENTION AND
RECOVERY INDIGENT SERVICES

UTAH COUNTY DIVISION OF SUBSTANCE ABUSE

.....a Division of the Utah County Health Department

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PERMISSION TO SHARE INFORMATION WITH PROVIDERS PARTICIPATING IN UTAH COUNTY'S INTEGRATED SUBSTANCE ABUSE TREATMENT NETWORK

NAME: _____ DOB: _____ CT ID: _____

I give permission for Utah County Division of Substance Abuse staff and the following agencies, who participate in the UCDSA Integrated Substance Abuse Treatment Service Network, to share information about me that is or may be used for the purpose of providing services, coordinating, and implementing my treatment:

- Utah County Health Department
- Project Reality
- Institute for Cognitive Therapy
- Utah County Jail
- Wasatch Mental Health
- Department of Workforce Services
- House of Hope - Provo
- Division of Child & Family Services
- NEFA
- Crossroads

The extent of information to be disclosed is my diagnosis, information about my attendance or lack of attendance at treatment sessions, drug test results, my cooperation with the treatment program, prognosis, and information that will aid in the delivery of my ongoing treatment and will only be shared with those who need to know.

I understand these agencies will keep the information confidential to the extent allowed by Federal Law governing confidentiality of alcohol and drug abuse patient records, 42 CFR, Part 2 & (HIPAA) 45 CFR 160-164, and that confidential information about me cannot be disclosed without my written consent. I also understand that I may revoke this consent in writing at any time except to the extent that agencies have already taken action in reliance on it.

This consent is valid until ***treatment is completed and court case is closed + sixty days.***

Signature: _____ Date: _____

Witness: _____ Date: _____

Signature of Parent or Guardian: _____ (If Applicable)

NOTICE: YOU (THE CLIENT) SHOULD OBTAIN A COPY OF THIS RELEASE UPON SIGNING

STAFF DO NOT LEAVE ANY BLANK LINES IN THIS DOCUMENT

NOTICE: This electronic communication may contain protected health information, the release of which is restricted by federal law. Any information about a client or clients has been disclosed to you from records protected by federal confidentiality rules governing federally-assisted drug or alcohol abuse programs (42 C.F.R., Part 2) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R, Part 2, and HIPAA. A general authorization is NOT sufficient for this purpose.

The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client. Any unauthorized redisclosure of the information contained in this communication may be punishable under federal statutes.