ROADWAYS TO RECOVERY
MENTAL HEALTH AND ADDICTION TREATMENT

821 N State Road 135
Greenwood IN, 46142

Phone: 812-675-8849
Fax: 812-292-5431

Authorization for Use and/or Disclosure of Protected Health Information (PHI)

_____ _____
Last Name First Name M.I. Date of Birth

_____
Street Address City State Zip Code

_____
Home/Cell Phone

I, _____, request and authorize Roadways to Recovery

- ☐ Release my information to: _____
- ☐ To receive my information from (marking both boxes indicates your authorization for **Two Way Communication** between the identified people/facilities

Person/Facility Name: _____

Address: _____

Phone: _____

Fax: _____

The following information

- ☐ Entire medical record
  - ☐ *or*
- ☐ Dates of Service _____ to _____

(please check)

☐	Assessments	☐	Cooperation, Motivation	☐	Prognosis
☐	Discharge/Transfer	☐	Financial Information	☐	Presence in Treatment
☐	Medication	☐	Nursing/Medical Assessment	☐	Psychiatric Evaluation
☐	Presence in Treatment	☐	Prognosis	☐	Psychosocial Evaluation
☐	Drug testing	☐	Treatment Plan Summary	☐	Toxicology Reports/ Drug Screen

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment when appropriate, and coordinate treatment services. If other purpose please specify _____

Unless sooner revoked, this consent is valid for **12 months** due to the need for ongoing communication for the coordination of treatment and will expire on the following date:_____.

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Conditions:

I understand that Roadways to Recovery will not condition my treatment on whether I give authorization for the requested disclosure. The consequences of refusing to sign this authorization have been explained to me.

Form of Disclosure:

Unless you have requested in writing that disclosure be made in a certain format, we reserve the right to disclose information as permitted by authorization in any manner we deem to be appropriate and consistent with applicable law, including but not limited to verbally, in paper format, or electronically.

Re-disclosure:

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R Part 2. Other types of information may be re-disclosed by the recipient of the information. **I may request a copy of this authorization for my records.**

I understand that my records are protected under Federal Confidentiality regulations (42 CFR Part 2). Published August 10, 1987, and the Health Insurance Portability and Accountability Act of 1996 (P.L 104-191), 42 U.S.C. Section 1320d, et. Seq, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that my medical record may contain information concerning my psychiatric, psychological, drug and alcohol abuse, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions. (Under the Mental Health Code, release of mental health records must be germane to the purpose and need for disclosure).

Right to Revocation:

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notice to Roadways to Recovery..

I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Signature:_____ Date:_____

Printed Name:_____