LANCASTER COUNTY DRUG AND ALCOHOL COMMISSION

Consent to Release Confidential Information

Multiple Case Management Facilities

Individual's FULL Legal Name: _____

Today's Date: _____

Date of Birth: _____

I, _____, do hereby consent to and authorize the Lancaster County Drug and Alcohol Commission to release relevant information to the following entities:

Please check all that apply:

☐ **PA Counseling Services Designate**, 40 Pearl Street, Lancaster, PA 17603, Phone- (717) 397-8081

☐ **Blueprints for Addiction Recovery, Inc. Designate**, 1901 Olde Homestead Lane, Lancaster, PA 17601 Phone- (717) 361-1660

☐ **Naaman Center/Ascend Behavioral Health Designate**, 436 North Lime Street Lancaster, PA 17602 Phone- (717) 394-5495

☐ **GateHouse Behavioral Health Services Designate**, 817 North Cherry Street, Lancaster, PA 17602, Phone- (717) 393-3215

☐ **Community Care and Addiction Recovery Services Designate**, 141 E. Main Street, Leola, PA 17540, Phone- 1-570-875-4700

☐ **R-3 Designate,** 150 South Prince Street, Lancaster, PA 17603, Phone- (717) 610-2555

☐ Other (include name of agency/program; address; telephone number):

_____

It has been explained to me and I am in agreement to permit the following specific information* to be disclosed (*there must be a detailed description of how much and what kind of information may be disclosed, including explicit description of SUD information to be disclosed, of which should be limited as possible): **Information regarding the participants agreement to engage in Case Management Services and complete a Recovery Plan in order to receive an LCDAC Recovery House Scholarship.**

Furthermore, it has been explained to me and I understand that the reason for the release of information is solely for the purpose of (***a detailed description of the reason of the disclosure; should be as specific as possible*):

☐ Coordinating treatment efforts.

**Explain in detail: _____

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☒ Coordination of and status report of my identified non-treatment-related needs.

Explain in detail: **The participant must engage in Case Management Services to maintain eligibility for the LCDAC Recovery House Scholarship. Participation must be verified by LCDAC.

☐ Other

**Explain in detail: _____

*I understand that the information being disclosed is from the records in which the confidentiality of its contents is protected by Federal Regulation 42 CFR, Part 2. Federal Regulation 42 CFR, Part 2 prohibits any further disclosure, unless further disclosure is expressly permitted by **MY written consent**, or as otherwise permitted by such regulations. A general authorization of the release of medical or other information is not sufficient for this purpose.*

I understand that I may revoke this consent at any time by notifying (verbally or in writing) a LCDAC staff or designate, except to the extent that action has been taken in reliance of my consent AND/OR, when applicable, if I am a client of the criminal justice system in which there has been a formal action by a Judge or documentation that the DA is putting me on ARD AND where copies of the legal order that state I must be in treatment to continue under such a disposition are in my client record, then and only then, federal regulations 42 CFR Part 2, Subpart C, 2.35 , stipulate that I cannot revoke the consent to release drug & alcohol treatment information to the criminal justice system until after the court stipulated condition has been met.

As indicated in my RIGHTS as an individual involved in the SUD treatment system, I understand that whenever this consent is utilized, documentation of the exchange of information shall be made of which every effort shall ensue to inform me of the exchange. Furthermore, I may inquire at any point about said exchange of information.

I understand that if I refuse to consent to disclosure for purposes of treatment, payment, or healthcare operations, that services may be denied. If, however, I refuse to consent for any other purposes, I will NOT be denied services.

_____ _____

Individual's Signature Date

Expiration Date: _____ *(Specify date, event, or conditions; cannot be longer than reasonably necessary to serve the purpose of the consent)*

Check appropriate box: ☐ I have accepted a copy of this document ☐ I have declined a copy of this document