**STATE OF CONNECTICUT**



**ACCESS TO RECOVERY IV PROGRAM (ATR IV)**

Department of Mental Health & Addiction Services

Phone: 1-866-580-3922 Fax: 1-866-580-4322

**CONSENT TO DISCLOSURE AND RE-DISCLOSURE OF CONFIDENTIAL INFORMATION AND RECORDS**

I, , DOB: ,

(Name of Patient) (Date of Birth)

EMS#: , SS#: as a

(EMS Number) (Social Security Number)

participant in the DMHAS Access To Recovery IV Program (ATR IV), understand my support services will be coordinated through DMHAS and the DMHAS designated Administrative Service Organization (ASO). I authorize the following individuals and organizations to release and exchange information to each other for the purpose of processing ATR Requests:

1. The DMHAS Administrative Service Organization; and

2.

3.

This information may include: my name, address, age, gender, Social Security Number, clinical assessment, progress in care, the type and outcome of mental health and addiction services I have received/am currently receiving, Access To Recovery IV Program (ATR IV) support history and such other information as is necessary to provide effective coordination of the treatment and services I receive.

The purpose of the disclosure authorized herein is to facilitate the provision of Access To Recovery IV Program (ATR IV) recovery supports.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2 and Chapter 899 of the Connecticut General Statues, and cannot be disclosed without my written consent unless otherwise provided for in the regulations or statutes. I have received a summary of the federal law protecting this information and a statement of the intended use of this information. I understand that the federal regulations restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient, and I understand that the rules prohibiting re-disclosure to third parties without my written consent will be strictly adhered to. I also understand that I may revoke this at any time except to the extent that action has been taken in reliance on it. Unless revoked by me, this consent shall expire upon completion of this application, or:

[Specific date, event or condition upon which this consent expires, only if different from above]

*(If blank, authorization will expire 12 months from date of signature below)*

Date:

(Signature of Participant)

(Signature of parent, guardian or authorized representative where required)