



STATE OF CONNECTICUT
ACCESS TO RECOVERY II PROGRAM (ATR II)
Department of Mental Health and Addiction Services

Phone 1-866-580-3922

Fax application to: 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 II Program (ATR II), 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 Access To Recovery II Program (ATR II) 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 II Program (ATR II) 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 II Program (ATR II) 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 Statutes, 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]

Date: _____

(Signature of Participant)

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

THIS PAGE MUST BE FAXED TO ABH