

Project SAFE
Consent to Release Information and Authorization for Payment

I, _____, DOB: _____, ABH# _____, SS# _____, as a
(REQUIRED: Name of Patient, Date of Birth, ABH Number & Social Security Number)
participant in the Project SAFE Program, understand that my case planning for child protective services,
and treatment and support services will be coordinated. I authorize:

1. Advanced Behavioral Health, Inc., (ABH)
2. The Department of Children and Families, (DCF)
3. The Department of Mental Health and Addiction Services (DMHAS)
4. _____
[Required: Name of treatment program making disclosure]
5. _____
[Optional: Name of additional agency, if applicable]

to communicate about my care with one another and to disclose to and receive from one another the following information: records accessible through the ABH, DCF, and DMHAS information systems, my name, address, age, gender, Social Security Number, mental status, psychiatric and/or substance abuse diagnoses, my reason for treatment, treatment and illness history, treatment plan, medication(s), substance(s) used, drug screen results (including urine and hair tests) clinical risk, relapse potential, legal status, progress in care, natural supports and personal strengths, the type and outcome of services I receive and such other information as is necessary to provide for case planning for child protective services and effective coordination of, and payment for, the treatment and services I receive (excluding HIV-related information unless such disclosure is specifically authorized by me or required by law). In addition, the following information may be disclosed:

[Describe any additional information]

The purpose of the disclosure authorized herein is to facilitate case planning for child protective services, the provision, coordination and monitoring of my care and support services, payment for services, and to evaluate the Project SAFE program and the care and services I receive. In addition, the disclosure is made to achieve the following purpose(s):

[OPTIONAL: Any additional purpose of disclosure]

I understand that my records are protected under the federal regulation 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. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. I understand that the disclosure may occur in face-to-face contact, telephonically, via mail, and/or facsimile. Unless revoked by me, this consent shall expire automatically when I am discharged from my current treatment episode 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)

PROHIBITION ON RESDISCLOSURE OF INFORMATION CONCERNING CLIENT IN ALCOHOL OR DRUG ABUSE TREATMENT

This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). 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 CFR Part 2. A general authorization for the release of medical or other information 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 patient.