LUK, Inc.	**Behavioral Health Services**
545 Westminster Street, Fitchburg, MA 01420	***Authorization to Use and Disclose Health Information***

Client Name:		**Client ID#**
Admit #:		**LUK Staff:**
Admit Date:	**Date of Consent:**	

SECTION A: USE OR DISCLOSURE OF HEALTH INFORMATION

By signing this Authorization, I authorize the use or disclosure of ☐ my ☐ my child's ☐ the person's for whom I am guardian individually identifiable health information ☐ maintained by: ☐ to and from:

The Provider [Person/Organization(s) providing the information]:

Print Name and Role of Staff

Print Address

☐ my ☐ my child's ☐ the person's for whom I am guardian

The Provider [Person/Organization(s) receiving the information]:

Print Name and Role of Staff

Print Address

Health information includes information collected from me or created by the Provider, or information received by the Provider from another health care provider, a health plan, my employer or a health care clearinghouse (e.g., a billing service). Health information may relate to my past, present or future physical or mental health or condition, the provision of my health care, or payment for my health care services.

I understand that the Provider is prohibited from disclosing information about treatment for alcohol or drug abuse, HIV status, or genetic testing without my specific written authorization unless, with regard to information about treatment for alcohol or drug abuse, a disclosure is otherwise authorized by federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).

I understand that under state law, the Provider is prohibited (i) from disclosing information about my HIV status without my specific written authorization (G.L. c. 111, 704F), and (ii) from disclosing the results of a genetic test (including the identity of a person being tested) without first obtaining an authorization that constitutes "informed written consent," except (1) pursuant to court order, (2) for use in epidemiological or clinical research and (3) to a person whose official duties, in the opinion of the commissioner of public health, entitles him or her to receipt of such information (G.L. c. 111, 70G).

SECTION B: SCOPE OF USE OR DISCLOSURE

Health information that may be used or disclosed through this Authorization is as follows (Check as many as apply):

☐ All health information about me, including my clinical records, created or received by the Provider, excluding HIV, AIDS information and genetic testing (If needed utilize Authorization to Use and Disclose Health Information: HIV/AIDS, Genetic Testing).

☐ Information pertaining to the identity, diagnosis, prognosis or treatment for alcohol or drug abuse maintained by a federally-assisted alcohol or drug abuse program.

(Indicate as many as apply. Client or guardian must initial each selection)

☐ Initial Assessment	☐ Psychiatric Evaluation	☐ Educational History/Status
☐ Treatment Plan	☐ Psychotherapy Notes	☐ Psychological Evaluation/Testing Report
☐ Termination Summary	☐ Physical Examination/Status Report	☐ Alcohol/Drug Use Evaluation/Report
☐ Other (please specify):		

All health information about me as described in the preceding checkbox(es), excluding the following:

☐ Specific health information *including only*:

Note: Describe the health information to be excluded or included in a specific and meaningful fashion.

Effective 08/11/14

LUK, Inc.
545 Westminster Street,
Fitchburg, MA 01420

SECTION C: PURPOSE OF THE USE OR DISCLOSURE
The purpose(s) of this Authorization is (are):
☐ ***Regarding general health information:*** ☐ Assessment ☐ Service/Treatment Planning ☐ Discharge Planning
☐ Specifically, the following purpose(s): ______________________________
or
☐ The Client has initiated the request for information to be used or disclosed and the Client does not elect to disclose its purpose. *Note: This box may NOT be checked if the information to be used or disclosed pertains to alcohol or drug abuse identity, diagnosis, prognosis or treatment.*

☐ ***Regarding substance abuse information:*** ☐ Assessment ☐ Service/Treatment Planning ☐ Discharge Planning
☐ Specifically, the following purpose(s): ______________________________

SECTION D: EXPIRATION This authorization will remain in effect until (choose one):
☐ 90 days from date below ☐ 6 months from date below ☐ Discharge from treatment (if within 1 year)
☐ Other (Insert applicable event or date – mm/dd/yy): ______________________________
Note: If an expiration event is used, the event must relate to the Consumer or the purpose of the use or disclosure.

NOTE: THIS AUTHORIZATION IS VALID FOR NO MORE THAN 1 YEAR FROM THE DATE OF SIGNATURE.

For More Information Please Refer to your Notice of Privacy Practices

1. I understand that the Provider cannot guarantee that the Recipient will not redisclose my health information to a third party. The Recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a consumer in a federally-assisted alcohol or drug abuse program, the Recipient is prohibited under federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the consumer or as otherwise permitted under federal law governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).
2. I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment (or payment, if applicable) from L.U.K. Crisis Center, Inc., except when I am (i) receiving research-related treatment or (ii) receiving health care solely for the purpose of creating information for disclosure to a third party,
3. I understand that I may revoke this Authorization in writing at any time, except that the revocation will not have any effect on any action taken by the Provider in reliance on this Authorization before the Provider receives written notice of revocation. I further understand that that I must provide any notice of revocation in writing to the Chief Executive Officer or her/his designee at L.U.K. Crisis Center, Inc. The address of the Chief Executive Officer or her/his designee is 545 Westminster St., Fitchburg, MA 01420.
4. *This paragraph is only applicable to certain Authorizations to disclose health information for marketing purposes:* **I understand that L.U.K. Crisis Center, Inc. may, directly or indirectly, receive remuneration from a third party in connection with the marketing activities undertaken by the agency.**

I have read and understand the terms of this Authorization. I have had an opportunity to ask questions about the use or disclosure of my health information.

Client's signature: ______________________ Date of signature: ______________

Print Client's full name: ______________________________

Client's Home Address: ______________________________

Client's Home Telephone: ______________________ Date of Birth: ______________

When client is not competent to give consent, the signature of a parent, guardian, health care agent (proxy) or other representative is required.

Signature of legal representative: ______________________ Date of signature: ______________

Print name: Relationship of representative to client:

SUBSTANCE ABUSE REDISCLOSURE NOTICE

PROHIBITION ON REDISCLOSURE OF CONFIDENTIAL INFORMATION

This notice accompanies a disclosure of information concerning a consumer in an alcohol or drug abuse treatment program, made to you with the consent of such consumer.
This information has been disclosed to you from records protected by federal confidentiality rules governing federally assisted drug or alcohol abuse programs (42 C.F.R., 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 C.F.R., 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 consumer.

Effective 08/11/14