Affinity Clinical Services, PLLC

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION CRIMINAL JUSTICE SYSTEM REFERRAL

42 CFR Part 2 and HIPAA

I, _____, authorize
[Client's Name]

Affinity Clinical Services, PLL 5624 Executive Center drive #105, Charlotte, NC 28212 to obtain or release and exchange information specified below (including paper, oral, and facsimile interchange) with the following parties:

Initial all that apply: ___ NC Department of Community Corrections (PO): _____

X____ NC DMV X ____ **NC** Division of MH/DD/SAS __ _____
[Name of the Criminal Defense Attorney]

☐ _____ ☐ _____ ___ _____
[Name of the appropriate court] *[Name of the prosecuting District Attorney]* *[- Other -]*

the following information:

X___ my diagnosis, urinalysis results, information about my attendance or lack of attendance at treatment sessions, my cooperation with the treatment program, prognosis, and/or

X___ E508, Assessment, Driving Record, Blood alcohol Concentration reading or copy of the DWI police ticket

[describe how much/what kind of information may be disclosed, including & explicit description of what substance use disorder information may be disclosed; as limited as possible] for the purpose of Coordinating substance abuse and/or DWI care.

[describe the purpose of the disclosure; as specific as possible]

I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Client Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows: _____or

One year from the date signed _____. *[describe date/event/ condition upon which consent will expire; must be no longer than reasonably necessary to serve the purpose of this consent]*

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form.

X Dated: _____ X_____
Signature of client

Dated: _____ _____
Signature of person signing form if not client

_____
Describe authority to sign on behalf of client

Dated: _____ _____
Witness/Staff Signature

Notice Prohibiting re-disclosure of Substance Use Disorder Information: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a client as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed 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 (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any client with a substance use disorder, except as provided at §2.12(c)(5) and §2.65.