

The Addiction Center of Broome County, Inc.

30 West State Street Binghamton, New York 13901

Phone (607) 723-7308 Fax (607) 724-4626

Carmela Pirich, LCSW, MBA
Executive Director

Dr. Florante Tinio, MD
Medical Director

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ DOB: _____ authorize
(Name of Client/Patient)

(Agency name and address)

to communicate with and exchange information with the Dual Recovery Project as represented by: Dual Recovery Coordinator, Addiction Center of Broome County, Catholic Charities of Broome, Fairview Recovery Services, Inc, New Horizons, United Health Services Hospitals, Broome County Department of Social Services, Broome County Mental Health Department, Dual Recovery Consumer Advocate, Chemical Dependency Services Unit, Greater Binghamton Health Center, MHASt, Family and Children's Society, Lourdes Center for Mental Health, Our Lady of Lourdes Hospital

I authorize the release of the following information:

<input type="checkbox"/> My name and other personal identifying information	<input type="checkbox"/> Psychiatric/Psychological consults
<input type="checkbox"/> My status as a patient in treatment	<input type="checkbox"/> Medications prescribed
<input type="checkbox"/> Date(s) of admission(s)	<input type="checkbox"/> Psychosocial history
<input type="checkbox"/> Evaluation/Assessment and disposition	<input type="checkbox"/> Status of medical coverage
<input type="checkbox"/> Diagnosis/brief description of progress/prognosis	<input type="checkbox"/> Housing status
<input type="checkbox"/> Medical history & physical examination results	<input type="checkbox"/> Discharge summary/Aftercare plan
<input type="checkbox"/> Results of diagnostic tests & testing(labs,PPD,Xray,urine)	<input type="checkbox"/> Legal status/history
<input type="checkbox"/> Other	

This information is needed for the following purpose:

Presentation of the case as part of the Dual Recovery Treatment Workgroup and/or the Dual Recovery Review Committee for the purpose of facilitation of mental health/chemical dependency treatment and coordination of services when indicated.

I have read the above and authorize the staff of the releasing organization/program identified above to release information described above. I understand that this authorization may be withdrawn by me in writing at any time. I am aware that my revocation does not effect information already disclosed. This authorization shall expire six (6) months from its signing, unless a different time period is specified below, in which case the time period specified below shall apply *. I also understand that any release is in accordance with Title 42 of the Code of Federal Regulations that governs the release of alcohol and drug records, as well as the Health Insurance Portability and Accountability act of 1996 ("HIPAA") 45 C.F.R. Pts. 160 & 164; and that redisclosure of this information to any organization/program/person other than described above is forbidden without additional written authorization on my part. I understand that there is no provision for redisclosure of mental health patient records. I also understand that a specialized separate release of information is required for the disclosure/release of records pertaining to HIV.

***One year from date of signing**

Signature of Client or Personal Representative

Printed Name of Client

Date

Printed name of Personal Representative

Description of Authority of Personal Representative

Signature of Witness

Printed Name and Relationship of Witness

Date

BUILDING A FOUNDATION FOR RECOVERY
Licensed by New York State Office of Alcohol and Substance Abuse Services

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