

Portland Recovery Group Authorization to Release or Obtain Confidential Information

(Please complete this form carefully as it is a critical document for proper coordination of care)

I, _____, Social Security Number: ____-____-____, born on ____/____/____ authorize Portland Recovery Group and:

Name of Person/Agency: _____

Address: (Street, City, State, Zip) _____

Phone: Cell Number: _____ Fax Number: _____

Email Address: _____

Relationship to Patient: _____

_____ To disclose (Please initial)

OR

_____ To obtain (Please initial)

The Following Information (Please initial all selections):

_____ Presence in treatment	_____ Laboratory test results
_____ Medical history/current	_____ Discharge summary
_____ Aftercare recommendations	_____ Psychological assessment
_____ Admission Status	_____ Employment information
_____ Progress in treatment	_____ Legal status
_____ Biopsychosocial assessment	_____ Results of physical exam
_____ Discharge planning	_____ Family information
_____ Treatment plans	_____ Other: _____

For the purpose of (Please initial all selections) :

_____ Continuity of treatment - Patient history - Coordination of care
_____ General Updates
_____ Emergency contact
_____ Court services - Legal purposes - Probation - Disability claiming - Unemployment claiming -
_____ Employment continuity -
_____ Compliance with state regulations
_____ Other: _____

Information may be shared in the following ways (Initial selections below):

_____ Oral _____ Written _____ Electronic

Statement on Risks of Electronic Communication (42 CFR Part 2 and HIPAA)

I understand that while electronic communication methods such as **email, text messaging, fax, or other digital platforms** can be convenient, they also involve risks to the privacy and security of my **Protected Health Information (PHI)** and **Substance Use Disorder (SUD) treatment records** protected under **42 CFR Part 2** and **HIPAA**.

Specifically, I acknowledge and understand that:

1. **Electronic communications may not be secure.** Messages can be intercepted, misdirected, forwarded, stored, or accessed by unauthorized persons.
2. **Encryption is not guaranteed.** Even if encryption is used by Portland Recovery Group, the receiving system (such as my own email, mobile phone, or the recipient's system) may not be secure.
3. **Unauthorized access is possible.** Devices such as phones, tablets, or computers may be lost, stolen, or shared, which could expose my health information.

4. **Redisclosure may occur.** Once my information leaves Portland Recovery Group's secure systems, the recipient may not be subject to the same confidentiality protections. Any further disclosure by that recipient may **no longer be protected by 42 CFR Part 2 or HIPAA.**
5. **Electronic delivery errors can occur.** Messages could be sent to the wrong address or may fail to be received due to technical issues beyond Portland Recovery Group's control.
6. **I may opt out at any time.** I have the right to revoke this consent in writing, and Portland Recovery Group will then stop communicating my PHI/SUD information electronically.

By signing this form, I accept these risks and authorize Portland Recovery Group to communicate or disclose my PHI, including SUD information, using electronic means as specified in this consent. I understand that Portland Recovery Group will make a sincere effort to keep my information secure.

If I have been diagnosed or treated for any of the following, I understand that my specific consent to disclose related information is necessary. (Must Initial selections below)

_____ **I Do** _____ **I Do Not** Authorize disclosure of information which refers to treatment or diagnosis of drug or alcohol abuse. Such information may not be re-disclosed by the recipient without my specific written consent.

_____ **I Do** _____ **I Do Not** Authorize disclosure of information which refers to mental health/psychiatric treatment or diagnosis

_____ **I Do** _____ **I Do Not** Authorize disclosure of information which refers to treatment or diagnosis of HIV/AIDS.

_____ **I Do** _____ **I Do Not** Wish to look at the information before it is released. This review must be documented.

Expiration: 365 days from date of signature or other if specified here _____

I understand that my records are protected under Federal regulations, (42CFR, Part2), and the Health Insurance Portability Accountability Act (HIPAA), 45 C.F.R., pts 160 & 164, 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, and that, in any event, this consent expires automatically one year from the date signed, otherwise unless specified below. I understand that generally Portland Recovery Group may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances support or collateral investigation is a key component and we may not be able to meet your needs without the key contacts involvement. I understand I am entitled to a copy of this document in its complete form.

Client's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

For Revocation Purposes Only

I hereby revoke my authorization to release my substance use disorder treatment information. I understand that this revocation does not apply to information already released under my previous authorization.

Client Signature: _____ **Date:** _____