CMS Client ID: _____ Client DOB: _____ Client Insurance ID: _____

RELEASE OF INFORMATION (GENERAL)

Authorization/consent to disclose protected health information including HIV & AIDS related information, and substance use disorder information

Community Medical Services

I, _____, hereby authorize Community Medical Services and its subsidiaries (the **"Practice"**), to exchange (verbal or written) my protected health information, including substance use disorder information (collectively, the **"Records"**) with **RDS (INFO@RECDEP.COM)** (the **"Recipient"**). Specifically, the Records that may be disclosed include (select all that apply); absence of a checkmark indicates that information is not permitted for disclosure: ☑ *Check this box to allow both parties indicated to disclose and receive information*

- ☐ **Any and all records** *(check no other boxes)*
- ☐ Emergency contact only
- ☐ Billing records
- ☐ Diagnosis/prognosis
- ☐ Discharge summary
- ☐ Case notes
- ☐ Other:
- ☐ Drug screens
- ☐ Treatment plans
- ☐ Prescribed medications
- ☐ Immunization records
- ☐ Physician orders
- ☐ Dental history
- ☐ Date of last dose
- ☐ Dose amount
- ☐ Behavioral health assessments & updates
- ☐ Admission/enrollment information
- ☐ Nursing assessment
- ☐ Coordination of care: letter of introduction, status report, updates
- ☐ Take-home medication status
- ☐ Communicable disease information (including TB and RPR results)

For dates of service between _____ and _____, or the last two years if not specified. Disclosure under this Authorization is for the purpose of:

This Authorization will remain effective until ☐ 90 days post-discharge from the Practice or ☐ _____, at which time it will expire. If no date is set forth above, the Authorization will remain effective for one year from the signature date below, at which time it will expire. A photocopy of this Authorization will be considered effective and valid as the original.

I understand I have the right to revoke this Consent, in writing, at any time by sending such written notification to the attention of the Practice. I understand my revocation will not be effective to the extent the Practice or other lawful holder permitted to make the disclosure has already acted in reliance on the Authorization.

I understand that neither the Practice nor the Recipient may condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization. In addition, I understand that the Recipient may redisclose the Records and that the Records may no longer be protected by the Federal privacy regulations at 45 CFR Part 164, Subpart E.

I acknowledge and agree that the protected health information authorized to be disclosed under this Authorization may include records for substance use disorder or psychiatric illness, and records of testing, diagnosis or treatment for HIV, HIV-related diseases, and communicable disease-related information.

With respect to any communicable disease-related information protected by State confidentiality rules and disclosed under this Authorization, the Recipient is prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by applicable law.

Further, with respect to any substance use disorder treatment information disclosed under this Authorization, this information has been disclosed from records that may be protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit the Recipient from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is 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 substance use disorder patient.

Signature of CLIENT		**Date**	
Signature of PARENT/GUARDIAN/PERSONAL REPRESENTATIVE *if applicable*		**Date**	
Provide a description of authority to act on behalf of patient:			