NEW YORK STATE
OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

Revoked On:_____ Staff Initials:_____

Patient's Last Name	First	M.I.
CASE No.		
FACILITY	UNIT	

CONSENT TO RELEASE PERSONAL IDENTIFYING INFORMATION CONCERNING ALCOHOL/DRUG ABUSE TREATMENT HISTORY **FOR THE PURPOSE OF OBTAINING INSURANCE BENEFITS**

INSTRUCTIONS: **GIVE COPY OF FORM TO PATIENT.** Keep an original of this release.

PATIENT'S CONSENT TO DISCLOSE PERSONAL IDENTIFYING INFORMATION

EXTENT OR NATURE OF INFORMATION TO BE DISCLOSED

I _____hereby give _____ , the New York State Office of Alcoholism and Substance Abuse Services, New York State Dept of Health, New York State Insurance Dept, New York State Attorney General's Office, and my insurance provider, permission to release information to, communicate with, and disclose among themselves information relating to insurance billing, benefits, and reimbursement, including the minimal clinical information necessary related to billing, benefits and reimbursement problems, for services I have received from this program.

PURPOSE OR NEED FOR DISCLOSURE

To permit the New York State Office of Alcoholism and Substance Services, New York State Dept of Health, New York State Insurance Dept, the New York State Attorney General, to assist both me and my drug treatment provider in obtaining access to insurance benefits and reimbursement for services rendered.

I, the undersigned, have read the above and authorize the staff of _____ , New York State Office of Alcoholism and Substance Services, New York State Department of Health, New York State Insurance Department, New York State Attorney General's Office and my insurance provider to disclose and obtain such information as herein specified. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it, and that in any event this consent expires automatically as follows:

☐ When issues relating to billing, benefits and reimbursement have been resolved, or

☐ _____
(Specify other time when consent can be revoked and/or expires)

I also understand that any disclosure/release of any identifying information is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient 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 that information to a party other than the one designated above is forbidden without additional written authorization on my part

NOTE: Any information released through this form will be accompanied by the form Prohibition on Redisclosure of Information Concerning Alcoholism/Drug Abuse Patient

I further understand that my treatment will not be conditioned on whether I sign this consent form. I have received a copy of this form, as recognized by my signature below.

_____ (Signature of Patient)

_____ (Signature of Parent/Guardian, when required)

_____ (Print Name of Patient)

_____ (Print Name of Parent/Guardian)

_____ (Date)

_____ (Date)

Describe authority to sign on behalf of patient _____