Revoked On:	Staff Initials:

Arms Acres AUTHORIZATION AND CONSENT TO RELEASE INFORMATION FROM THE PATIENT RECORD

PATIENT NAME	DATE OF ADMISSION	DATE OF BIRTH	PATIENT NUMBER

I do hereby consent and authorize Arms Acres, Inc. to obtain from and release to:

NAME OF ORGANIZATION(S)	NAME OF PERSON(S) AND/ OR POSITION
STREET ADDRESS, INCLUDING APARTMENT OR SUITE NO. IF APPLICABLE	
CITY, STATE AND ZIP CODE	
PHONE NUMBER, INCLUDING AREA CODE	FAX NUMBER INCLUDING AREA CODE

Select which information pertaining to this admission is to be disclosed:

- ☐ Presence in treatment (admit / discharge dates)
- ☐ Face Sheet
- ☐ Medical history and physical examination
- ☐ Nursing Assessment
- ☐ Psychiatric consults
- ☐ Other: ______________________________
- ☐ Diagnosis / brief description progress / notes
- ☐ Discharge summary / Aftercare Plan
- ☐ Results of diagnostic tests and testing (Lab, PPD, X-ray)
- ☐ Psychosocial Assessment
- ☐ Treatment Plans

This information is being disclosed needed for the following purpose(s) [select all that apply]:

- ☐ To provide ongoing treatment/ continuing care
- ☐ Obtain insurance, employment, government benefits
- ☐ To enable judges, attorneys, and probation / parole officers to support treatment goals & make legal decisions on my behalf
- ☐ Other: ____

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I choose to do so willingly and voluntarily for the purpose(s) specified above. The duration of this authorization is for this admission and no longer than 120 days, unless I specify a different date, event or condition upon which it will expire. I may revoke this consent at any time by notifying Arms Acres HIM department in writing, except to the extent that action has been taken in reliance on my authorization.
I understand that Arms Acres may charge a reasonable, cost based fee to provide the requested records for purposes other than for continuing care.

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")regulations at 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

Specify date, event, or condition upon which authorization expires, if different from above.	
Patient Signature	**Date**
Legal Representative Signature	**Date**

General Consent 03/2023 **AM - 14**

THIS INFORMATION WHICH HAS BEEN DISCLOSED TO YOU IS PROTECTED BY FEDERAL CONFIDENTIALITY RULES (42 CFR PART 2). THE FEDERAL RULES PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS RECORD 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 AND HIPAA. 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 PATIENT WITH A SUBSTANCE USE DISORDER, EXCEPT AS PROVIDED AT §§ 2.12(C)(5) & 2.65.