Authorization for Exchange of Confidential Information Form (Pre-Admission)

Client's Name:	DOB:

I authorize Triumph Treatment Services ("Triumph") to exchange (disclose and receive) my health information with the following parties for the purpose(s) set forth below:

☐ Primary Referent: **Purpose:** Treatment and care coordination	Name/Organization: Address:	Phone: Fax:
☐ Legal (DOC, Probation, Drug Court): **Purpose:** Comply with legal obligations and facilitate necessary treatment and rehabilitation.	Name/Organization: Address:	Phone: Fax:
☐ Emergency Contact: **Purpose**: Ensure timely communication and coordination of care in emergency situations.	Name/Organization: Address:	Phone: Fax:
☐ Transportation Contact: **Purpose:** Coordinate safe and efficient transportation arrangements.	Name/Organization: Address:	Phone: Fax:
☐ Other: **Purpose:**	Name/Organization: Address:	Phone: Fax:
☐ Other: **Purpose:**	Name/Organization: Address:	Phone: Fax:
☐ Other:	Name/Organization: Address:	Phone: Fax:

This release applies to the following types of records (check all items that apply):

Substance Use Disorder Treatment Records:

- ☐ All Substance Use Disorder Records (or specify below)
  - ☐ Assessment Results/Recommendations
  - ☐ Treatment Plans
  - ☐ Lab/UA Results
  - ☐ Presence and Attendance
  - ☐ Diagnosis
  - ☐ Progress Notes
  - ☐ Discharge Summary
  - ☐ Current Medications
  - ☐ Other: Demographics

Mental Health Treatment Records:

- ☐ All Mental Health Records (or specify below)
  - ☐ Treatment Plans
  - ☐ Lab/UA Results
  - ☐ Presence and Attendance
  - ☐ Diagnosis
  - ☐ Progress Notes
  - ☐ Discharge Summary
  - ☐ Current Medications
  - ☐ Other: Demographics

I understand that my records may be protected under federal regulations governing confidentiality of alcohol and drug abuse client records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided under applicable law. By my signature below, I understand and agree that the information that will be exchanged under this Authorization may include information about my diagnosis, testing, and/or treatments for sexually transmitted diseases, mental health services, and drug and/or alcohol services. I also understand Triumph may not condition the provision of treatment on my signing of this Authorization, except for disclosures for treatment, payment, or health care operations, or health care services that are solely for the purpose of creating health information for disclosure to a third party. 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. I further understand that any disclosure of health information carries with it the potential for an unauthorized re-disclosure and may not be protected by federal or state confidentiality laws.

This Authorization will expire one (1) year from the date signed. **By signing below, I acknowledge that I have read and agree to the terms on both sides of this form.**

Print Client Name:	Date:
Client Signature:	

* Parent or Guardian signature required if client is under the age of 13 years old.

Print Name:	Relationship to Client:	Date:
Signature (if applicable):		