POLICY: Montgomery County Drug and Alcohol Subcontracted D&A Providers shall adhere to all laws and regulations pertaining to the confidentiality of client records and the conditions under which some or all of that information may be released. Relevant statutes are:

- Act 63 71 P.S. § 1690.101 et seq. - established the Pennsylvania Advisory Council on Drug and Alcohol Abuse in 1972 whose authority was transferred to the Department of Health and addresses confidentiality requirements
- 28 Pa. Code Chapter 709 - standards for licensing freestanding treatment facilities to include adherence to confidentiality requirements
- 42 CFR Part 2 - federal regulation governing patient records and information
- 45 CFR Part 96 - federal regulation governing the privacy of health care information that went into effect on April 14, 2003
- 4 Pa. Code § 255.5 and § 257.4 - state regulations governing patient records
- Act 126 42 Pa. C.S.A. § 6352.1 - state law clarifying what information may be exchanged between children and youth agencies, the juvenile justice system, SCAs and treatment providers.

PROCEDURE: All client identifying information is to be considered confidential and may only be released with a signed client consent and is limited to the following information:

- Name of client
- Name of program disclosing the information
- Name of recipient/agency to which information is being disclosed
- Specific information to be released
- Purpose of disclosure
- Statement of clients’ right to revoke in writing or verbally their consent to release
- Expiration date
- Dated signature of client
- Dated signature of witness
- Indication of client’s acceptance or rejection of a copy of the release form
- Statement regulating redisclosure restrictions and penalties

EXCEPTION: The only exception to the written consent of the client relates to medical emergencies where the patient’s life is in immediate jeopardy. Client information may only be shared with proper medical authorities solely for the purpose of providing medical treatment to the patient or upon the order of the court of common pleas after an application showing good cause.

See Consent forms Attached.
See Policies: M468 and M469 for Consent Forms related to ACT 126
CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION between
ASSESSMENT/SCREENING/CARE MANAGEMENT (ACM) AND SERVICE PROVIDERS

I, _______________________________________, DOB ___________________________ Authorize

_________________________________________________

ACM Unit to release to __________________________________________

(Agency Name) (Person or Organization)

the following information from my client record:
Yes ___ N0 ___ LOC Assessment Results to include a copy of the PCPC Summary Form
Yes ___ N0 ___ Eligibility for Services
Yes ___ N0 ___ Recommendations for Ancillary services
Yes ___ N0 ___ Personal Demographics (DOB, SSN, Address, Phone)
Yes ___ N0 ___ Other (Specify) ____________________________________________

FOR THE PURPOSE(S) OF:
_________ Referral for D&A Treatment Services
_________ Validation of D&A Treatment Services
_________ Other (specify) _______________________________________________

And for ____________________________________________________________ to release to __________________________________________

(Person or Organization) (Agency Name)

the following information from my client record:
Yes ___ N0 ___ Personal demographics (DOB, SSN, Address, Phone)
Yes ___ N0 ___ PCPC Summary form, Participation and Progress in the program
Yes ___ N0 ___ Incidence of Relapse and Frequency
Yes ___ N0 ___ Prognosis
Yes ___ N0 ___ Diagnosis
Yes ___ N0 ___ Other (Specify) __________________________________________

FOR THE PURPOSE(S) OF:
_________ Validation of D&A Treatment Services
_________ Continued Stay Reviews
_________ Other (Specify) _______________________________________

I have read or had this form explained to me and I understand that:
• My records are protected under Federal and State regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records and cannot be redisclosed without my written consent unless otherwise provided for in the regulations.
• The individual or agency to which this information is sent is prohibited from redisclosing this information to another party.
• When applicable, Criminal Justice System clients who have agreed to enter treatment in lieu of prosecution or punishment may not revoke their consent that allows the Court, Parole, or other Criminal Justice agency from monitoring their progress in treatment.
• I may revoke this consent to release information at any time verbally and/or in writing, except to the extent that action has been taken in reliance of it.
• The consent given on this page will expire one year from the date of signature unless otherwise revoked by me OR as follows: ____________________________________________

(Specify a specific event or condition upon which this consent expires)

Date:_________________________Client Signature: __________________________________________

Date:_________________________Witness: __________________________________________

A copy of this release has been offered to me and I ______ accept _______ do not accept the copy.

□ Written Revocation: ____________________________ Date: ____________________________

□ Oral Revocation: ____________________________ Date: ____________________________

Rev. 7/04; 5/05; 5/06; 4/08
CONSENT TO RELEASE INFORMATION BETWEEN
DRUG AND ALCOHOL CASE/CARE MANAGEMENT (CM) AND THE COUNTY ASSISTANCE OFFICE

I, __________________________________________, DOB_________________________ AUTHORIZER

(Client Name)

Agency Name: ____________________________________________________________________________

The _______________________________ Case/Care Management Unit, to release to the Montgomery County
Assistance Office the following information from my client record:

Yes_____ No _____ Participation in Treatment     Yes_____ No ____ Progress in Treatment
Yes_____ No _____ Nature of the Project          Yes_____ No _____ Relapse History and Frequency
Yes_____ No _____ Prognosis

FOR THE PURPOSE(S) OF:
_____ Determining benefit eligibility for treatment services
_____ Other (specify) ______________________________

And for the Montgomery County Assistance Office to release to _______________________________ CM Unit
(Agency Name)

the following information from my client record:

Yes _____ No _____ Current eligibility and changes in eligibility
Yes _____ No _____ Conditions or criteria leading to benefit ineligibility as relates to ACT 35 changes and BHSI Funding

FOR THE PURPOSE(S) OF:
_____ To verify benefit eligibility

I have read or had this form explained to me and I understand that:

- My records are protected under Federal and State regulations governing Confidentiality of Alcohol and Drug Abuse Patient
  Records and cannot be redisclosed without my written consent unless otherwise provided for in the regulations.
- The individual or agency to which this information is sent is prohibited from redisclosing this information to another party.
- When applicable, Criminal Justice System clients who have agreed to enter treatment in lieu of prosecution or punishment
  may not revoke their consent that allows the Court, Parole, or other Criminal Justice agency from monitoring their progress
  in treatment.
- I may revoke this consent to release information at any time verbally and/or in writing, except to the extent that action has
  been taken in reliance of it.
- The consent given on this page will expire one year from the date of signature unless otherwise revoked by me OR as
  follows:

__________________________________________________________
(Specify a specific event or condition upon which this consent expires)

Date:_____________________________ Client Signature: ________________________________________________

Date: ____________________________  Witness: ________________________________________________________

A copy of this release has been offered to me and I ____ accept _______ do not accept the copy.

□ Written Revocation: ____________________________ Date: ____________________________

□ Oral Revocation: ____________________________ Date: ____________________________

(Staff/Designee Signature in Receipt of Oral Revocation)

Rev. 5/05; 5/06; 4/08
Appendix C

**Drug and Alcohol Clients**  
**Consent for the Release of Confidential Information**

I, ______________________________. (Date of Birth_________________) authorize ______________________________ to disclose to ______________________________ the following information:

( ) 1. Whether the client is or is not in treatment  
( ) 2. Prognosis  
( ) 3. Nature of the project  
( ) 4. A Brief discussion of client’s progress  
( ) 5. A short statement RE: Relapse and frequency of such Relapse

This information is needed for the purpose of:

( ) coordination of care  
( ) emergency contact  
( ) funding/benefit eligibility  
( ) follow-up services  
( ) ancillary services  
( ) Specify other: _______________________

I understand that my alcohol and/or drug treatment records are protected under Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 CFR, Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by regulation. When applicable, Criminal Justice System clients who have agreed to enter treatment in lieu of prosecution or punishment may not revoke their consent that allows the Court, Parole, or other Criminal Justice agency from monitoring their progress in treatment. I also understand that I may revoke this consent verbally and/or in writing at any time except to the extent that action has been taken in reliance on it, and that, in any event, this consent will expire one year from the date of signature OR as follows:

________________________________________________________
(Specify a specific event or condition upon which this consent expires)

I have accepted a copy of this form: ( ) Yes ( ) No

CLIENT SIGNATURE: ______________________________ DATE: ______________________________

WITNESS SIGNATURE: ______________________________ DATE: ______________________________

TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

□ Written Revocation: ______________________________ Date: ______________________________  
(Client Signature)

□ Oral Revocation: ______________________________ Date: ______________________________  
(Staff/Designee Signature in Receipt of Oral Revocation)

Rev. 7/04; 5/05; 4/08
CONSENT FOR RELEASE OF DRUG AND ALCOHOL CLIENT INFORMATION
Between
INTENSIVE CASE MANAGEMENT and SERVICE PROVIDERS

I, ____________________________, DOB ____________________________ AUTHORIZE (Client Name) to release to _________________________ (Agency Name) the following information from my client records:

_____ ISS Assessment
_____ Record of ISS Services Provided
_____ Referrals Follow Up
_____ Referral Contacts
_____ Incidence and frequency of Relapse
_____ Description of Progress in ICM
_____ Participation or lack thereof in ICM

FOR THE PURPOSE(S) OF:
_____ Coordinating/Monitoring Case Management efforts with other agencies/family/persons involved in my care
_____ To complete follow up

And for ____________________________ to release to ____________________________ (Person or Organization) to release to ____________________________ (CM Agency Name) the following information from my client records:

_____ LOC Assessment
_____ PCPC Summary
_____ Whether I Am or Not in Treatment
_____ Description of my Progress
_____ My Prognosis
_____ Diagnosis
_____ Referral Follow Up Status
_____ Whether I have relapsed and frequency of relapse

FOR THE PURPOSE(S) OF:
_____ Coordinating/Monitoring Case Management efforts with other agencies/family/persons involved in my services
_____ To complete follow up

I have read or had this form explained to me and I understand that:

- My records are protected under Federal and State regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records and cannot be redisclosed without my written consent unless otherwise provided for in the regulations.
- The individual or agency to which this information is sent is prohibited from redisclosing this information to another party.
- When applicable, Criminal Justice System clients who have agreed to enter treatment in lieu of prosecution or punishment may not revoke their consent that allows the Court, Parole, or other Criminal Justice agency from monitoring their progress in treatment.
- I may revoke this consent to release information at any time verbally and/or in writing, except to the extent that action has been taken in reliance of it.
- The consent given on this page will expire one year from the date of signature unless otherwise revoked by me OR as follows:

___________________________________________________________________________________________________

(Specify a specific event or condition upon which this release expires)

Date: ____________________________ Client Signature: ____________________________________________________________

Date: ____________________________ Witness: ________________________________________________________________

A copy of this release has been offered to me and I ______ accept ______ do not accept the copy.

☐ Written Revocation: ____________________________ (Client Signature) ___________ Date: ____________________________

☐ Oral Revocation: ____________________________ (Staff/Designee Signature in Receipt of Oral Revocation) ___________ Date: ____________________________

Rev. 7/04; 5/05; 4/08