

**RESIDENTIAL TREATMENT EXPANSION CONSORTIUM
AUTHORIZATION TO USE AND DISCLOSE
PROTECTED HEALTH INFORMATION**

I (name): _____, born on (DOB): _____

freely and voluntarily authorize _____ (name of referral source)

to use, disclose, discuss and exchange with the Residential Treatment Expansion Consortium (RTEC),
MCDC and/or Rimrock the following information:

- admission packet
- chemical dependency evaluation
- ASI information (if available)
- _____ (other)

Records may be disclosed via fax or mail. Treatment will not be conditioned on the provision of this authorization.

For purpose of admission consideration and ongoing care.

I understand that I have a right to revoke this authorization at any time. To revoke this authorization, I must submit a written request to RTEC at 1 Riverside Road Boulder MT, 59632. I understand that the revocation will not apply to information that has already been released in response to this authorization.

This authorization will expire one year following discharge from 3.1 level of treatment.

I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure, and the information may no longer be protected by federal confidentiality rules.

I have received a copy of this authorization.

Signature of Patient

Date

Witnessed By

Date

Personal Representative

Date

Witnessed By

Date

NOTICE TO WHOMEVER DISCLOSURE IS MADE: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as 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 alcohol or drug abuse patient.