



**Authorization for Use & Disclosure of Protected Health Information (PHI)
to the Access to Recovery (Anishnaabek Healing Circle Program)**

I, _____, hereby consent to disclose the following information
(Print Participant Name - subject of PHI)

to the _____, for the purpose of determining my eligibility for
(Print Name of Provider Organization or Individual)

substance abuse services, processing payments for service provided to me, and auditing the provider agency. I also authorize the re-disclosure of the authorized information between the named provider and the Inter-Tribal Council **Access to Recovery Anishnaabek Healing Circle Program** for the purpose of determining my eligibility for the services, processing payments for services provide to me, and auditing of the provider agency.

Check items to be disclosed: (To process payment for services all of these items must be checked.) The other item can be checked if disclosure of additional information is to be made, please specify the information.

- First, Middle, and Last Name
- Date of Birth
- Tribal Affiliation
- Follow-up Locator Information
- Screening Results(Score)
- Clinical Treatment Assessment Results (Diagnosis)
- Recovery Support Assessment Results
- Service Recommendations Based on Clinical Treatment Assessment
- Service Recommendations Based on Recovery Support Assessment
- Service Transactions
- Discharge Summary
- Other: _____

I understand that this authorization will remain in effect until 30 days after my discharge from the **Access to Recovery (Anishnaabek Healing Circle Program)** _____ .

I understand that I can request the termination of this authorization at any time. I also understand that termination of this authorization will not allow for the processing of payment for services and my services may be discontinued by the provider if no other resources are available. _____

Your Rights With Respect To This Authorization

General Statement of Rights: Federal and state laws protect the confidentiality of my PHI including but not limited to: 42 CFR Part 2 Final Rule governing confidentiality of alcohol and drug abuse patient records and that recipients of this information may redisclose it only in connection with their official duties to the organization specified on this form for the purpose stated. Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164. Right to Receive a Copy of This Authorization: I have a right to receive a copy of this form after I sign it. Right to Refuse to Sign This Authorization: I am under no legal obligation to sign this form however, under certain circumstances permitted under applicable law; refusal to sign may result in denial of services. Right to Withdraw This Authorization: I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to the individual/agency authorized to disclose PHI. My withdrawal of consent will not be effective until the individual/agency authorized to disclose PHI receives it, and will not be effective regarding the uses and/or disclosures of my PHI made prior to receipt of my withdrawal statement. Re-disclosure: If I authorize release of PHI to an individual or agency not covered by federal or state laws that prohibit re-disclosure, my PHI may not remain confidential. Right to Inspect and/or Copy PHI: I have the right to inspect and receive copies of my PHI as permitted by law. I may be charged a reasonable fee for these copies. I have read or had read to me the contents of this authorization. I have had an opportunity to discuss and ask questions. By signing this authorization, I am confirming that it accurately reflects my wishes regarding disclosures of my PHI. A photocopy, fax or electronic image of this authorization shall be as valid as the original.

Signature of Participant Who is Subject of PHI Date Signed

Signature of Other Person Legally Authorized to / Title or Relationship To Individual Date Signed