GENESIS
IN THIS TOGETHER
DEPARTMENT OF PHARMACY

Consent for Release of Confidential Information

For Coordination with Medical Providers

I, _____ herby authorize the disclosure of my below listed confidential and protected health and treatment information for the purpose of coordination of care between _____and Genesis Medical Center. The purpose or need for disclosure of the below information is to facilitate overall case planning, facilitate and communicate effective assessment of the client's needs, enhance the effectiveness of client treatment/recovery planning, inform contact person in the event of a clinical emergency, and report any critical incidents.

I herby authorize the disclosure of the following information to the treatment of my substance use disorder (SUD)

- Frequency of duration of contact with program
- Identifying information and status in SUD treatment
- SUD diagnosis(es)
- Results of evaluation, recommendations, and plans
- Summary of treatment participation and progress and outcomes
- Attendance schedule and compliance with my SUD provider
- Medical History and diagnoses
- Social History
- Legal History
- Known prescription information and outcomes from pill counts, if applicable
- Lab results including drug urinalysis results
- Psychological/Psychiatric Testing and evaluation
- Information relating to client emergency
- Iowa Medicaid Critical Incident Report

I herby authorize the disclosure of the following information from Genesis Medical Center

- Known medical concern or drug allergies
- Reason for medical visit, hospitalization, or ongoing medical care
- Medical Diagnosis(es)
- Record from medical visit(s) or hospitalization(s) including MAR
- Medical Recommendations
- Medical treatment plan for ongoing care recommendations
- Substance Use Disorder treatment records and/or Mental Health treatment
- Lengths of stays for inpatient care

I understand my records are protected under the Federal regulation governing Confidentially and Drug Abuse Patient records, 42 C.F.R. Part 2, and the Health Information Portability and Accountability Act of 1996, 45 C.F.R. Parts 160 & 164, and cannot be disclosed with my written consent unless otherwise provided for in the regulations. I also understand that I man revoke this consent 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 automatically expires one year from date of signature unless other specified here:_____

I hereby acknowledge that I have a received a copy or chosen to decline a copy of this document.

Required Signatures

_____	_____	_____
Patient signature (or parent/guardian)	Date	Patient Date of Birth
_____	_____	
Genesis Staff Signature	Date	