Heartland
Regional Alcohol
& Drug Assessment Center

P.O. Box 1063 • Mission, Kansas • 66222-0063 • Phone: 913-789-0951 or 1-800-281-0029 • Fax: 913-789-0954

Client Name:	DOB:

I authorize and request Heartland Regional Alcohol & Drug Assessment Center to communicate with the following individuals, providers, and/or agencies to exchange (send and receive) through disclosure and/or re-disclosure, information needed to coordinate and assist in coordinating my care, treatment and services.

Individual / Provider or Agency Name	**City**	**State**

By initialing, I am allowing communication with the entities noted above.

_____ Alcohol or Substance Use Information and/or Records (**CLIENT INITIALS ARE REQUIRED**)

To Include: • Clinical Treatment Plans / Notes • Authorizations • Denials / Grievances / Appeals • Claims Info / EOB's • Current Medication List • UA/BAL • Presence in Facility/Program • Letters/Correspondence/Emails • Other: _____

I understand that the information and records disclosed and/or re-disclosed pursuant to this consent are protected under 42 CFR Part 2 - Confidentiality of Substance Use Disorder Patient Records, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Health Information Technology for Economic & Clinical Health (HITECH) and 45 CFR parts 160 and 164, and State Confidentiality laws & regulations. This information cannot be released without my consent unless otherwise provided for by the regulations.

This authorization shall be in force and effect for one year or until I revoke it, in the manner described below or until (**insert expiration date or event**) _____ (whichever is shorter).

- I may revoke this consent at any time. But if revoked, the revocation will not affect the disclosure of any information that has already been disclosed / re-disclosed.
- As I authorize the release of alcohol or substance use information to a healthcare organization that is not my treating provider, I have the right, for the next two years, to request a list of entities to which my information has been disclosed, by contacting the organization directly and requesting that information in writing.
- I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or healthcare operations, as permitted by law. I will not be denied services if I refuse to consent to a disclosure for other purposes.
- Upon request, I will be provided a copy of this authorization.

Client Signature Required	Date Required

** If signing as the individual's Legally Authorized Representative, attach a copy of the appropriate legal document(s) granting you authority. Examples would be a health care power of attorney, a court order, guardianship papers, etc.*
***A financial or business power of attorney is NOT sufficient**.*