CASA
TRINITY
Hope begins, here.

CONSENT FOR RELEASE OF INFORMATION

I, _____ hereby authorize and consent to communication between

CASA-Trinity, Inc

and

Name: _____
Relationship: _____
Phone: _____

The extent of information to be disclosed:

The purpose or need for such disclosure:

I understand that my records are protected under the Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 && 164, and NYS HIV confidentiality law, PHL Article 27-F as it pertains to HIV related information and cannot be disclosed without my written consent unless otherwise provided for in regulations.

I understand that I may 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, unless specified below, this consent expires automatically **1 year** following the conclusion of services at CASA-Trinity, Inc.
Expiration date:

I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization. I understand that generally, CASA-Trinity, Inc may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

To the Recipient of this information: 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. (42 CFR § 2.32).

I have been provided a copy of this form

Client Signature _____ Date _____
Printed Name _____

Parent/Guardian Signature _____ Date _____
Printed Name _____

Witness Signature _____ Date _____
Printed Name _____