UNISON BEHAVIORAL HEALTH
1007 Mary Street, Waycross, Georgia 31501

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Section A: Use or Disclosure of Health Information
By signing this Authorization, I authorize the use or disclosure of my individually-identifiable health information maintained by: Unison Behavioral Health,1007 Mary Street, Waycross, Georgia 31501

My health information may be disclosed under this Authorization to the following recipient:

Name:____
Print Name

Address: ____
Print Address

Health information includes information collected from me or created by Unison Behavioral Health, or information received by the agency from another health care provider, a health plan, my employer or a health care clearinghouse. It may include details of alcoholism, drug abuse, sexual preferences / orientation, sexually transmitted disease, contraceptive use, pregnancy, abortion, domestic violence, sexual assault, transmitted disease, HIV test(s) or treatments, genetic information. Health information may relate to my past, present or future physical or mental health or condition, the provision of my health care, or payment for my health care services.

I understand that Unison Behavioral Health is prohibited from disclosing information about treatment for alcohol or drug abuse without my specific written authorization unless a disclosure is otherwise authorized by federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).

Section B: Scope and Use of Disclosure: *Check One:*

Health information that may be used or disclosed through this Authorization is as follows:

☐ **All health information about me, including my clinical records created or received by the Provider. This information may include, if applicable:**

- Information pertaining to the identity, diagnosis, prognosis or treatment for alcohol or drug abuse maintained by a federally-assisted alcohol or drug abuse program; or;
- Information concerning the testing for HIV (human Immune Virus) and/or treatment for AIDS (Acquired Immune Deficiency Syndrome and any related conditions.

☐ **All health information about me as described in the preceding checkbox, *excluding* the following:**

____

____

☐ **Specific health information *including only*:** ________________________

____

____

Note: Describe the health information to be excluded or included in a specific and meaningful fashion.

Section C. Purpose of Use or Disclosure

The purpose(s) of this Authorization is (are): *Check one:*

☐ Specifically, the following purpose(s)____

____

____; or

☐ The Client has initiated the request for information to be used or disclosed and the Client does not elect to disclose its purpose.
Note: This box may NOT be checked if the information to be used or disclosed pertains to alcohol or drug abuse identity, diagnosis, prognosis or treatment.

Section D: Authorization Expiration:____________________________________
(applicable event or date – mm/dd/yy)

Note: If an expiration event is used, the event must relate to the Consumer or the purpose of the use or disclosure.

Section E: Other Information of Importance

1. I understand that Unison BH cannot guarantee that the Recipient will not redisclose my health information to a third party. The Recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a consumer in a federally-assisted alcohol or drug abuse program, the Recipient is prohibited under federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the consumer or as otherwise permitted under federal law governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).

2. I understand that, except when I am (1) receiving research-related treatment or (2) receiving health care solely for the purpose of creating information for disclosure to a third party, I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment from Unison Behavioral Health.

3. I understand that I may revoke this Authorization in writing at any time, except that the revocation will not have any effect on any action taken by Unison Behavioral Health in reliance on this Authorization before written notice of revocation is received by Unison Behavioral Health. I further understand that I must provide any notice of revocation in writing to the Privacy Officer at Unison Behavioral Health. The address of the Privacy Officer is 1007 Mary Street, Waycross, Georgia 31501.

I have read and understand the terms of this Authorization. I have had an opportunity to ask questions about the use or disclosure of my health information.

Client's signature:______________________________ Date: ____________

Print Client's full name: ____________________________ DOB: ____________

Signature of legal representative: ____________________ Date of signature:____________

Print name: ____________________ Relationship of representative to client____________

Witness:________________Date________ Witness:________________Date________

Two Witnesses are required if consumer signs by a mark (x). One witness is required for all other signatures.

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SUBSTANCE ABUSE REDISCLOSURE NOTICE
PROHIBITION ON REDISCLOSURE OF CONFIDENTIAL INFORMATION

This notice accompanies a disclosure of information concerning a consumer in an alcohol or drug abuse treatment program, made to you with the consent of such consumer.

This information has been disclosed to you from records protected by federal confidentiality rules governing federally-assisted drug or alcohol abuse programs (42 C.F.R., 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 C.F.R., 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 consumer.