JSAS HealthCare, Inc.
"Working Together To Make Life Better"

RELEASE AUTHORIZATION – TREATING PROVIDER ENTITY

I, _____ , hereby give permission to JSAS HealthCare to release to and obtain
name of patient

from the staff members of _____ which has a treating provider
name of recipient entity, which has a treating provider relationship with the patient

relationship with the patient.

The following information from my records:

- ☐ Attendance
- ☐ Progress in Treatment
- ☐ Toxicology Results
- ☐ Discharge Summary
- ☐ Substance Use Disorder Evaluation
- ☐ Progress Notes
- ☐ Treatment Plan
- ☐ Doctor's Orders
- ☐ Medication Record
- ☐ Lab Results
- ☐ Other _____

_____

_____

_____

The purpose or need for such disclosure is _____.

This information may be given _____
indicate frequency

This consent is subject to revocation at any time except to the extent that action has been taken in reliance thereof and will expire on _____.
date, event or condition

I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder 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 cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

Patient Signature _____ Date _____

Witness Signature _____ Date _____