touchstone health services
partnering with families

Confidential Member Records Disclosure Authorization

I, _____, authorize Touchstone Health Services (THS) to disclose the necessary information, which may include records of drug abuse, alcoholism, sickle cell anemia, or human immunodeficiency virus (HIV) to the following participants of:

_____; and/or Contact Information: _____
_____; and/or Contact Information: _____
_____; and/or Contact Information: _____
_____; and/or Contact Information: _____
_____; Contact Information: _____

for the purpose of:

☐ **External Referral Packet** ☐ **Out of Home Placement Packet**
(Both Packets may contain the following but not limited to: Initial Assessment, current Annual Assessment; Service Plan/CFT; Child Adolescent Service Intensity Instrument (CASII); Diagnosis; Strength, Needs, Cultural Discovery (SNCD), Crisis Plans, Demographics, 90 days of most recent Med Notes, Most recent Psychiatric Evaluation, Meet Me Where I Am (MMWIA) Score)

☐ **Plan of Care – Communication with External Primary Care Providers**
(Contains the following: Diagnosis, Active Medications, Last PCP Visit, Diagnosis Follow for Labs, Referrals, Last Psychiatric Visit, Vital Signs, THS Services Provided)

☐ **Transfer of Services from THS to Another Provider**
(Contains the following: All Assessments, Service Plans, Progress Notes, Case Management Notes, CASIIs, SNCDs, Diagnosis, Psychiatric Assessments, Medication Monitoring Visits)

I understand that my or my child's records are protected under federal law, including the federal regulations governing the confidentiality of 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 Parts 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows:

Acceptance of External Referral Packet/Out of Home Placement Packet/Transfer to Another Provider or; One (1) year from the date signed below.

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

I have been provided a copy of this form.

Dated: _____ **Signature of Member: _____**

Signature of Person signing form if not Member: _____

Describe authority to sign on behalf of Member: _____

Date Revoked: _____ **Staff Name: _____**

NOTICE: 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 information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.