DELAWARE HEALTH AND SOCIAL SERVICES
Division of Substance Abuse and Mental Health
1901 North DuPont Highway, New Castle, Delaware 19720

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

In compliance with Federal Regulations (42 U.S.C. 4582 and 21 U.S.C. 1175) and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (45 C.F.R. Pts. 160 and 164), I, the undersigned,

Client Name: _____ Date of Birth: _____
Last Name First Name M.I. MM/DD/YYYY

SSN: ☐☐☐-☐☐-☐☐☐☐

do hereby authorize the DSAMH Eligibility & Enrollment Unit to disclose the information specified below to any of the following entities:

Brandywine Counseling, Inc.	Kirkwood Detox
Connections CSP	Limen House
Corinthian House	NHS
Delaware Psychiatric Center	Psychotherapeutic Services, Inc.
Division of Vocational Rehabilitation	Resources for Human Development
Fellowship Health Resources	Recovery Innovations
Gateway Foundation	Serenity Place
Gaudenzia	Tau House
Horizon House	Thresholds
Kent/Sussex Community Services	University of Pennsylvania (de-identified only)

Other: _____

This release is specific to information contained in: the **Eligibility & Enrollment Application Packet, ASI, Assessment Summary, ASAM Summary, Consumer Reporting Forms** (pages 1 & 2), **Eligibility & Enrollment Summary Sheet** and the **EEU Service Authorization Form**.

The purpose or need for this disclosure is to coordinate my behavioral health care treatment.

I understand that my records are protected under Federal regulations governing **Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2,** and the **Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 and 164** and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also 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. I understand that my private health information, once disclosed to others, may be redisclosed to individuals or organizations not subject to HIPAA and may no longer be protected by HIPAA. I understand that generally DSAMH may not condition my treatment on whether I sign an authorization form, but that in certain limited circumstances I may be denied treatment if I do not sign an authorization form.

This consent extends from this date until 60 days post discharge from DSAMH-contracted services.

Signed _____ Date _____

By ☐ _____
Client OR Specify Relationship (if signed by other than client)