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 Transition Age Youth Unit to disclose the information specified below to any of the following entities:

____ Aquila Delaware
____ Banyan Delaware
____ Brandywine Counseling, Inc.
____ Conexio Care
____ Coras Wellness
____ Corinthian House
____ Division of Developmental Disability Services
____ Division of Medicaid & Medical Assistance
____ Division of Social Services
____ Division of Vocational Rehabilitation
____ Fellowship Health Resources
____ Gateway Foundation
____ Gaudenzia
____ Horizon House
____ Hudson Health Services
____ Kirkwood Detox
____Limen House
____Psychotherapeutic Services, Inc.
____ Recovery Innovations
____ Serenity Place
____ Thresholds
____Tau House

Other: ____

This release is specific to information contained in: the **Transition Age Youth Brief Screen, Client Action Referral Plan, 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. **This consent extends from this date until 365 days post discharge from DSAMH-Transition Age Youth-contracted services.** 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.

Signed ____ Date _____________________

By ☐ ____

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