PAS
Peer Assistance Services

Leading with prevention and intervention for substance use and mental health concerns

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____
(Print client's first, middle, last name)

Hereby authorize Peer Assistance Services, Inc. (PAS) to disclose/receive the following information concerning me to/from

_____
(Name of individual or entity) (Phone)

_____
(Name of patient's treating provider) (Email)

_____
(Street Address) (City) (State) (Zip) (Fax)

Items and information to be released are:

- ☑ Treatment records
- ☑ Testing results
- ☑ Emergency-related information
- ☑ Reports of compliant and/or non-compliant behavior
- ☑ Assessment summary and/or recommendations
- ☑ Screening tool information
- ☑ Ability to practice with reasonable skill and safety
- ☑ Records to be used for payment and/or health care operations, as illustrated in 42 C.F.R § 2.33
- ☑ Other _____
(specific record or records)

The purpose of this disclosure is: _____.
This disclosure is limited to information which is necessary to carry out my stated purpose.

The confidentiality of substance use disorder (SUD) patient records ("SUD records") maintained by PAS is protected by Federal laws and regulations. Generally, PAS may not say to an individual or entity outside the program that a client involved with PAS attends the program or disclose any SUD records—unless: 1) You consent to the disclosure of SUD records in writing; 2) The disclosure is ordered by a court; or as otherwise mandated by State and/or Federal law; 3) The disclosure is made to medical personnel either in a medical emergency in which your written consent cannot be obtained, or in the event that a state or federal authority declares a state of emergency as the result of a natural or

major disaster and the part 2 program is closed and unable to provide services or obtain your informed consent; or 4) The disclosure is made to qualified personnel for research, audit, or program evaluation.

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. If not sooner revoked, this consent shall expire two (2) years after my discharge from Peer Assistance Services, Inc. (42 C.F.R. § 2.31)

A copy of this document will have the same force and effect as the original.

_____ _____

Client Signature Date

PEER ASSISTANCE SERVICES, INC.
2170 South Parker Road, Suite 229 | Denver, Colorado 80231 | 303.369.0039 | 200 Grand Avenue, Suite 270 | Grand Junction, Colorado 81501 | 970.986.4360 | PeerAssistanceServices.org

PEER HEALTH ASSISTANCE PROGRAMS Nurses | Dentists | Pharmacists | Veterinarians | Psychologists | Social Workers | Professional Counselors | Marriage and Family Therapists | Unlicensed Psychotherapists
Addiction Counselors | Emergency Medical Service Providers • SBIRT IN COLORADO Screening, Brief Intervention, and Referral to Treatment • PUBLIC AWARENESS CAMPAIGN One Degree: Shift the Influence

START BELIEVING.