



from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

- I have the right to inspect the health information to be released and I may refuse to sign this authorization.
- Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity will not condition the provision of treatment or payment for my care on my signing this authorization.

**The information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.**

**I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.**

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Legal Representative's Authority

\_\_\_\_\_  
Expiration Date of Authorization

**NOTICE OF RIGHTS:** Information in your medical record that you have or may have a communicable, venereal or non-communicable disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court of the Department of Health, disclosure among health care providers or disclosure for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, by an order of the court or the Department of Health or by law.