SBIRT IN PRIMARY CARE

Release of Information

mosaic GROUP

I, (print name) _____ authorize

(referring agency) _____ to disclose:

Any information needed to coordinate a referral to treatment/recovery support services including health information related to my office visit. They are also authorized to discuss information about my drug and alcohol use and treatment engagement and retention.

To: _____, the provider to which I am being referred for services and care.

The purpose of this disclosure is to coordinate care.

I also ☐ **do authorize** or ☐ **do not authorize** _____ to request information about the above-named patient from the above-named organization for service coordination, collaboration, continuity of care, and case management activity. Please write any exceptions to this request for information:

Date:_____ Signature of Patient:_____

This consent will expire one year (365 days) after the signature date unless the patient requests verbally or in written form that consent be denied sooner than that date.

This information has been disclosed to you from records protected by Federal confidentiality rules (Title 42, Part 2, Code of Federal Regulations [42 C.F.R. Part 2]). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the individual to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.