For CBI Personnel to complete
MRN: _____

COMMUNITY BRIDGES INC

Consent for Disclosure of Confidential Information

Client Name (First and Last): _____ **DOB**: _____

Social Security#: _____ **AHCCCS ID#:** _____

I hereby authorize: Community Bridges, Inc.
(Fax): 480-755-2453 Email: MedicalRecords@cbridges.com
To: ☐ Release ☐ Verbal Communication ☐ Revoke

To release the information requested below to (will not be processed without this information):

Name/Agency: _____

Address:_____

Phone: _____ **Fax**: _____ **Email**: _____
CBI is not responsible for the confidentiality and security of your protected health information once it has been emailed to the address you have provided.

Amount of Information to be released (specify): _____

Information to be released in the following format(s): ☐ Written ☐ Verbal ☐ Electronic

Purpose of disclosure:_____

Nature of information to be released:

☐Discharge Summary	☐Psychiatric Eval	☐Verbal Consult – Reciprocal
☐Treatment Plan	☐Medication Log	☐Substance Abuse Information
☐Treatment Plan Update	☐Diagnosis	☐HIV Related Information
☐Standard Assessment	☐Monthly Summaries	☐Other **(must specify)**: _____

Notice: Alcohol and drug abuse patient records are protected by Federal confidentiality (regulations (42 CFR part 2). The Federal regulations prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person (to whom it pertains or as otherwise permitted by 42 CFR part 2.) A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal regulations restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Communicable disease related information, pursuant to this release, cannot be redisclosed without specific written authorization. (A.R.S. 36-664.11)

REVOCATION CLAUSE: I understand I may revoke this authorization at any time by writing to Community Bridges at the email address above or by letter to the CBI Privacy Officer.

Today's Date: _____ **Expiration Date**: _____ **Timeframe**: _____

This authorization will expire one year after the signature date, or _____, whichever is sooner. A photocopy of this Authorization will be considered as effective and valid as the original.

I have received a copy of this release (patient initials): _____

Patient Signature: _____ **Date:** _____

Parent/Guardian Signature (if applicable): _____ **Date**: _____

Witness Signature: _____ **Date**: _____

BLANK CONSENT FORMS SIGNED BY CLIENT WHEN SERVICE IS INITIATED DO NOT MEET COMPLIANCE STANDARDS