New Moon Lodge
579 White Swan Rd.
Ohkay Owingeh. NM 87566
505. 852-2788 Fax: 505. 852-2790

CONSENT FOR RELEASE OF INFORMATION

Client Name: ___________________________

Client DOB: _____________________

I hereby authorize: **ENIPC, Inc. New Moon Lodge**
P.O. Box 969
Ohkay Owingeh, New Mexico 87566

To ☐ release to and/or ☐ receive from: *Person/Entity* ____
To communicate with and disclose to one another the following information: *(nature of the information, (as limited as possible)*

Initial each category that applies:

☐ Demographics ☐ Medication Records ☐ Treatment Plans/Reviews
☐ Breathalyzer Results ☐ Psychiatric Assessment ☐ Treatment Status/Compliance
☐ Urinalysis Results ☐ Discharge Summary/Recommendations
☐ Substance Use and Mental Health Assessment/Screening Results
☐ Verbal Communication with Above Named Entity/Person
☐ Other: ____

Purpose of this release: *(enter reason, i.e., client request, coordination of services, Court Order to Disclose, etc.)*

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I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 Code of Federal Regulations (CFR) Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

Specify the date, event, or condition upon which this consent expires.

______ The date I that my New Moon Lodge Service are discontinued, or

______ Other:

If no date, event, or condition is specified, this consent will expire upon discharge from COLBHN.

I hereby release ENIPC, Inc., Behavioral Health Network, DBA Circle of Life - New Moon Lodge from all legal responsibilities or liability that may arise from disclosure of medical records in reliance on this Authorization. I understand that I have the right to examine and copy the information to be disclosed as well as to require a copy of this completed authorization.

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Signature of Client	Date
Signature of Authorized Representative (when required)	Date
Signature of Staff	Date

Notice Prohibiting Redisclosure of Alcohol or Drug Treatment Information

Prohibition on Redisclosure of Confidential Information

This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules, 42 Code of Federal Regulations (CFR), 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 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 rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.