PATIENT CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____, authorize Beacon Health Group, LLC staff

to disclose to my insurance company the following information:

- Documentation of assessment, attendance and compliance in substance use behavioral health treatment
- Urine drug screen results
- Clinical rationale to support continuation of therapy or to make changes in therapy

The purpose of the disclosure authorized herein is to:

- Determine my eligibility for benefits, billings or claims payment
- Prior Authorizations

I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, 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:

- Patient is no longer insured OR upon program discharge

Date: _____ **Printed Name:** _____

Signature of Patient or Authorized Representative: _____

Practice Representative: _____

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