maximus

**Release of Information – Information Related to Substance Use and Treatment**

**Comprehensive Assessment for Treatment (CAT)**

Your Name:_____ Birth date: _____

**Permission to Share Drug Use Related Information**

The following people or organizations listed below can share information related to drug use history, symptoms, diagnoses, medications, and treatment to help Maximus complete the New Hampshire Comprehensive Assessment for Treatment. (This authorization is made in accordance with 42 CFR Part 2.)

I, _____,
[Your name]

authorize _____
[Names of people or organizations that may share information]

to disclose: ☐ All my drug use records
**OR**
Only these types of records [Mark all that apply]:

| | |
|---|---|
| ☐ Appointments | ☐ Lab Results |
| ☐ Demographics | ☐ Medication(s) |
| ☐ Discharge Summary | ☐ Tests and Results |
| ☐ Drug Use History | ☐ Trauma History |
| ☐ Insurance Info | ☐ Treatment Plan and Progress |
| ☐ Other: _____ | |

to Maximus New Hampshire Comprehensive Assessment for Treatment to complete the Comprehensive Assessment for Treatment process.

I understand that my records are protected under Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2), and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")(45 CFR Parts 160 and 164) and cannot be shared without my written permission unless otherwise provided for in the regulations. I also understand that I may remove this permission at any time except to the extent that action has been taken in reliance on it and that removing my permission will not change information that was already shared. This permission expires:

☐ in 180 days from the date of my signature

OR

☐ upon a specific date or event as listed here: _____
[Specific date or event]

Return this completed and signed form to: **Maximus, Attn: NH CAT Division**
**Fax 1.877.431.9568 or Email: NHCAT@maximus.com**

I understand that (1) I may be denied services if I refuse to consent to disclosure for purposes of treatment, payment, or healthcare operations, if permitted by state law, and (2) I will not be denied services if I refuse to consent to a disclosure for other purposes.

I received a copy of this form.

_____ _____

Signature Date

**What if I change my mind?**

This permission can be removed by calling or writing Maximus at:

Maximus
2555 Meridian Blvd Suite 350
Franklin, TN 37067
Phone: 1.833.736.4228
Email: NHCAT@maximus.com

I understand that I may stop this permission at any time but that removing my permission will not change information that has already been shared.

Return this completed and signed form to: **Maximus, Attn: NH CAT Division**
**Fax 1.877.431.9568 or Email: NHCAT@maximus.com**