Janus of Santa Cruz
MAT Program

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____, authorize

_____to disclose

to/receive from _____Janus of Santa Cruz_____ the following information:

- Medical Intake
- TB Test(s) & Chest X-Rays (If Applicable) & RPT Test(s)
- Last Three (3) Months' UA Results
- Last Three (3) Months' Dispensing Logs
- Date of Last Dose (Quantity)
- Step Information
- Certification of Admit
- Med Sheet

This disclosure may be verbal, written or electronic.
The purpose of the disclosure authorized herein is to:

Transfer Treatment of Patient to Janus of Santa Cruz MAT Program

☐ Janus Community Clinic
1000A Emeline Ave.
Santa Cruz CA 95060
P(831)425-0112 F(831)425-1847

☐ Janus South County
284 Pennsylvania Ave. Suite 1
Watsonville CA 95076
P(831)319-4200 F(831)319-4204

I understand that my records are protected under the federal regulations Governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, as well as HIPAA 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 one year from the date of my signature or as follows:

_____
(Specification of the date, event or condition upon which this consent expires)

_____

Dated: _____ _____
Signature of Participant

_____
Signature of Representative