Resident Confidentiality Rights

It has been explained to me that both verbal and written information about me is protected under federal confidentiality regulations (42 CFR Part 2). This information cannot be shared without written consent, unless otherwise provided for in the regulations.

I also understand that there are limits to my confidentiality:

1. If I state that I have intentions of physically harming another person, I understand that Oasis House staff will report this information to law enforcement.
2. If I state that I am going to attempt to commit suicide or otherwise engage in self-harm, then I understand that Oasis House staff will report this information to law enforcement.
3. If I state that I have abused or am currently abusing a child, I understand that Oasis House staff will report this information to law enforcement.
4. I understand that the court can subpoena Oasis House records to be used in a court of law or subpoena staff to testify in court. Oasis House will only provide these records or testimony when presented with a valid court order.
5. I may review and/or obtain a copy of my file at any time with the assistance and supervision of the Program Director; and
6. I may revoke this consent at any time except to the extent that action has taken place. Upon revocation of consent, Oasis House will provide me with a copy of my file and will destroy all internal copies.

_____ _____

Resident Signature Date

_____

Witness Signature

Resident Release of Information

Applicant Name _____
Full Address _____
Date of Birth _____ Social Security Number _____
Maiden/Previous Name(s) _____

I authorize the following Agency/Organization/Business to release information or records about me to Oasis House.

Name: _____

Address: _____

The Purpose of this Release is to allow Oasis House to provide case management services. Please release the following information as indicated below:

☐ YES ☐ NO Medical (specify) _____

☐ YES ☐ NO Psychiatric/Psychological (specify) _____

☐ YES ☐ NO Legal (specify) _____

☐ YES ☐ NO Education (specify) _____

☐ YES ☐ NO Other (specify) _____

It is understood that the person authorizing release of this information has the right to inspect and copy the information to be disclosed that this information will not be re-disclosed without proper authorization. I understand that 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 once disclosed, information may be re-disclosed by the recipient and no longer protected.

I understand that this authorization is voluntary and that I may refuse to sign. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment(s), or my eligibility for benefits. This authorization expires one year from the date of my signature unless I specify a different event, purpose, or alternative expiration date here: _____.

_____ _____

Client Signature Date