DAUPHIN COUNTY DEPARTMENT OF DRUG AND ALCOHOL SERVICES
1100 South Cameron St. – 1st Floor Right, Harrisburg, PA 17104
Phone: (717) 635-2254 – Confidential Fax: (717) 635-2267

REQUEST FOR TREATMENT APPROVAL – FY2023-2024

CPR-Web Entries

- **Demographics** (Update if client already exists in system.)
- **Address** (Update if client already exists in system.)
- **Episode: Demographics, Admission, Diagnosis Code, Additional Demographics**
  (Update demographics only if episode is already open.)
- **Liability** (Not required for evaluations, withdrawal management only, or adolescents.)
- **Encounter Authorization** (Authorizations must follow SCA guidelines – refer to chart for time frames and units):
  ***ALL notes regarding the status of an authorization are written in CPR Web under "Provider Notes" in this section.**

Level Of Care:	Authorization Timeframes:	CPR Authorization Units:
GPRA	**1 day**	**1 unit**
Assessment	**1 day**	**1 unit**
Methadone	**6 months**	**184 units**
Outpatient (1.0)	**6 months**	**OP Group – 192 units** **OP Individual - 24units**
Intensive Outpatient (2.1)	**10 weeks**	**IOP Group - 180 units** **IOP Individual - 20 units**
Partial Hospitalization (2.5)	**10 weeks**	**PHP Group - 50 units** **PHP Individual – 10 units**
Halfway House (3.1)	**30 days initial** **Every 15 days ongoing**	**30 units** **15 ongoing**
Clinically Managed High Intensity Residential (3.5)	**14 days initial** **Every 7 days ongoing**	**30 units** **15 ongoing**
Withdrawal Management (3.7 WM) **Medically Managed Inpatient (4.0)** **Medically Managed Inpatient Withdrawal (4 WM)**	**5 days initial** **Everyday ongoing**	**5 units** **1 ongoing**

Attachments in CPR to Initial Authorization:

Demographics Sheet (Page 1 of packet)

Consents (SCA to Provider)

Treatment Limitations Form

Liability Form

Grievance and Appeal Form

Consent to CM Services Form

Case Management Service Plan
(All areas MUST be filled in.)

Proof of Identification
(If no ID, must document reason.)

GPRA, GPRA Locator Form, GPRA Consents
(If applicable.)

PA WITS Entries: *See DDAP's CMCS Manual for all WITS requirements.

Client Information

Client Intake

Screening Tool

Admission/Referral

ASAM

Consent to T-Dauphin SCA: (Client Info, Intake, Screening Tool, Admission/Referral, ASAM, Discharge*)

Referral to Dauphin County (Refer to SCA Case Management only if the client has a case management need.)

*Discharge – Provider **MUST** document Reason for Discharge once client completes treatment successfully or is discharged from program for any reason.

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REQUEST FOR TREATMENT APPROVAL – FY2023-2024

NAME: _____ **DATE OF INITIAL CONTACT:** _____

SSN: _____ **BIRTH NAME:** _____

CURRENT ADDRESS: _____ **DOB:** _____

_____ **RACE:** _____

MARITAL STATUS: _____ **PHONE # :** _____

GENDER: _____

HOME ADDRESS OF RESIDENCE ***(IF DIFFERENT FROM ABOVE)*****:** _____

WAS MA APPLIED FOR? ***(CIRCLE ONE)*****:** YES NO

WHAT IS THE MA STATUS? ***(CIRCLE ONE):*** APPLIED PENDING DENIED

CONFIRMATION NUMBER (MUST INCLUDE): _____

IF MA OR PRIVATE INSURANCE IS ACTIVE, WHAT IS THE REASON FOR THE FUNDING REQUEST?

(Explain) _____

IS INDIVIDUAL PREGNANT? YES NO **IS INDIVIDUAL A WOMAN WITH DEPENDENT CHILDREN?** YES NO

CO-OCCURRING INDIVIDUAL? YES NO **IS INDIVIDUAL A VETERAN?** YES NO

EVER BEEN AN INJECTION DRUG USER? YES NO **INTERIM SERVICES OFFERED?** YES NO

OVERDOSE SURVIVOR? YES NO

CURRENT DRUG OF CHOICE: _____

WAS A GPRA COMPLETED? *(Must be completed for individuals with opiate or stimulant use disorder)* **(CIRCLE)** YES NO

ASSIGNED STAFF COMPLETING LOCA (If applicable)

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TREATMENT LIMITATIONS FORM

This agreement is between the funding agency, Dauphin County Department of Drug and Alcohol Services, and _____.
(Individual)

All individuals must sign this form regardless of Level of Care recommendation or no treatment determination. The following is a list of terms for this agreement:

1. Individuals are eligible for one (1) Level of Care Assessment per six (6) months. This includes Level of Care assessments completed by the Dauphin County Department of Drug and Alcohol Services' staff or its contracted treatment providers.
2. The individuals agrees that if housing services are requesting, the individual must participate in services recommended based on the licensed drug and alcohol assessment. if the individual fails to participate in recommended services for any reason, the Dauphin County Department of drug and Alcohol Services will not fund for housing services. Emergency housing funding may be eligible for up to thirty (30) days.
3. The individual is eligible to receive a lifetime maximum of (1) year of funding for Medications for Opioid/Alcohol Use Disorder unless additional funding is available.

   ***Treatment limitations do not apply to priority populations**

My signature below indicates I have read, and/or had read to me, the information above:

_____ _____
Client Signature Date

_____ _____
Witness Signature Date

I have been offered a copy of this document. Please initial: Accepted ( ) Declined ( )

Revised 6/2023

CLIENT LIABILITY DETERMINATION FORM

(Please refer to Section 7.08 of the DDAP Fiscal Manual for completion of the form.)

☐ Initial
☐ Re-determination

Date: _____

Client Name	County of Residence	Client ID #

PART I: INSURANCE

Does the client have insurance (private and/or public) coverage? Yes ☐ No ☐

If insurance has been denied, indicate the reason for denial.

Denied:

Insurance Company	Name of Insured	Group #	ID #

If the SCA is not reimbursing for the cost of service or the service is exempt, DDAP does not require completion of the form.

PART II: FAMILY (As determined by Federal Law/Federal Tax Return)

Name of Dependents	Relationship
	Self

Total # of Dependents (including Self): _____

PART III: MONTHLY GROSS INCOME

List all income from full- and part-time employment as well as other types of income, as applicable, including that of Self, Spouse and Parents (see Section 7.03 of the DDAP Fiscal Manual for income to be included). See description of types of income below.

Family Member	Employers
Self	
Spouse	
Parent I (if applicable)	
Parent II (if applicable)	

Types of Income	Self	Spouse	Parent I	Parent II	Totals
Earned Income (i.e., wages, salaries, tips, bonuses, etc.)					$0
Interest Income					$0
Dividends					$0
Benefits (i.e., unemployment, social security, public assistance, pensions, etc.)					$0
Alimony					$0
Other Taxable Income					$0
Totals	$0	$0	$0	$0	$0

Total Monthly Gross Income $0

DESCRIPTION OF TYPES OF INCOME

Earned Income:	Wages, salaries, fees, commissions, tips, bonuses, net business income and other earned income subject to Federal income taxation.
Interest Income:	Interest income including, but not limited to, interest received from accounts with banks, savings and loan associations, money market funds, credit unions or bonds.
Dividends:	Dividends received from corporate stock holdings or cash dividends from life insurance policies.
Benefits:	Taxable benefits, including but not limited to unemployment compensation, Social Security payments and pensions. Benefits are counted as income only if the benefit is paid on behalf of the client. Food stamps are not counted as income.
Alimony:	Includes alimony received or spousal support received prior to divorce. Does not include child support.
Other taxable income:	Includes all other income subject to Federal income taxation, e.g., rental income, lottery winnings, net capital gains, etc.

PART IV: CLIENT LIABILIT - Refer to Liability Chart on next page

Total # of dependents (listed in Part II): ____

Total Monthly Gross Income (listed in Part III): $ ____

		CLIENT LIABILITY DUE							
Service	Applicable Liability Percentage*	Individual Hour	Group Hour	Group Session	Day	Week	Urinalysis	Dosing	Other (Specify)
Outpatient									
IOP									
Partial									
Halfway House									
Residential									
Methadone									
Other (specify)									

*Minimum co-pays may apply

AGREEMENT AND UNDERSTANDING:

I certify that the information concerning my dependents, insurance and income is true and complete to the best of my knowledge. I understand that I am responsible for paying the above fees on the same day of service. I understand that I am to notify this agency if there are any significant changes in my monthly income or family size within 30 days of such change. I understand that if these fees represent a financial burden, a staff person and I may fill out a REQUEST FOR LIABILITY REDUCTION OR ELIMINATION form.

A copy of this form has been offered to me and I have _____accepted _____rejected it

_____ _____

Client Signature Date

_____ _____

Staff Signature/Witness Date

_____ _____

SCA Signature (as applicable) Date

Note: Client Liability determined on this day shall be valid for a period of no more than 12 months, with a re-determination to occur at the end of the 12-month period.

LIABILITY CHART

Outpatient Drugfree

Note: Liability assessed as percentage of unit rate

Family Size	Monthly Income Equal to or Less Than										Monthly Income Greater Than
1	$1,884	$2,072	$2,261	$2,449	$2,637	$2,826	$3,014	$3,203	$3,391	$3,579	$3,579
2	$2,551	$2,806	$3,061	$3,316	$3,571	$3,826	$4,081	$4,336	$4,591	$4,846	$4,846
3	$3,217	$3,539	$3,861	$4,182	$4,504	$4,826	$5,148	$5,469	$5,791	$6,113	$6,113
4	$3,884	$4,272	$4,661	$5,049	$5,438	$5,826	$6,214	$6,603	$6,991	$7,380	$7,380
5	$4,551	$5,006	$5,461	$5,916	$6,371	$6,826	$7,281	$7,736	$8,191	$8,646	$8,646
6	$5,217	$5,739	$6,261	$6,783	$7,304	$7,826	$8,348	$8,869	$9,391	$9,913	$9,913
7	$5,884	$6,472	$7,061	$7,649	$8,238	$8,826	$9,414	$10,003	$10,591	$11,180	$11,180
8	$6,551	$7,206	$7,861	$8,516	$9,171	$9,826	$10,481	$11,136	$11,791	$12,446	$12,446
9	$7,217	$7,939	$8,661	$9,383	$10,104	$10,826	$11,548	$12,270	$12,991	$13,713	$13,713
10	$7,884	$8,672	$9,461	$10,249	$11,038	$11,826	$12,614	$13,403	$14,191	$14,980	$14,980
Client Liability:	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

Intensive Outpatient/Partial Hospitalization

Family Size	Monthly Income Equal to or Less Than						Monthly Income Greater Than
1	$1,884	$2,449	$3,014	$3,579	$4,145	$4,710	$4,710
2	$2,551	$3,316	$4,081	$4,846	$5,611	$6,376	$6,376
3	$3,217	$4,182	$5,148	$6,113	$7,078	$8,043	$8,043
4	$3,884	$5,049	$6,214	$7,380	$8,545	$9,710	$9,710
5	$4,551	$5,916	$7,281	$8,646	$10,011	$11,377	$11,377
6	$5,217	$6,783	$8,348	$9,913	$11,478	$13,043	$13,043
7	$5,884	$7,649	$9,414	$11,180	$12,945	$14,710	$14,710
8	$6,551	$8,516	$10,481	$12,446	$14,412	$16,377	$16,377
9	$7,217	$9,383	$11,548	$13,713	$15,878	$18,043	$18,043
10	$7,884	$10,249	$12,614	$14,980	$17,345	$19,710	$19,710
Client Liability:	0%	10%	20%	30%	40%	50%	100%

Inpatient Hospital/Non-Hospital Residential Treatment

Note: Liability assessed as set dollar amount per day

Family Size	Monthly Income Equal to or Less Than								
1	$1,884	$2,072	$2,261	$2,449	$2,637	$2,826	$3,014	$3,203	$3,391
2	$2,551	$2,806	$3,061	$3,316	$3,571	$3,826	$4,081	$4,336	$4,591
3	$3,217	$3,539	$3,861	$4,182	$4,504	$4,826	$5,148	$5,469	$5,791
4	$3,884	$4,272	$4,661	$5,049	$5,438	$5,826	$6,214	$6,603	$6,991
5	$4,551	$5,006	$5,461	$5,916	$6,371	$6,826	$7,281	$7,736	$8,191
6	$5,217	$5,739	$6,261	$6,783	$7,304	$7,826	$8,348	$8,869	$9,391
7	$5,884	$6,472	$7,061	$7,649	$8,238	$8,826	$9,414	$10,003	$10,591
8	$6,551	$7,206	$7,861	$8,516	$9,171	$9,826	$10,481	$11,136	$11,791
9	$7,217	$7,939	$8,661	$9,383	$10,104	$10,826	$11,548	$12,270	$12,991
10	$7,884	$8,672	$9,461	$10,249	$11,038	$11,826	$12,614	$13,403	$14,191
Client Liability:	$0	$5	$10	$15	$20	$25	$30	$35	$40

Family Size	Monthly Income Equal to or Less Than							Monthly Income Greater Than
1	$3,579	$3,768	$3,956	$4,145	$4,333	$4,521	$4,710	$4,710
2	$4,846	$5,101	$5,356	$5,611	$5,866	$6,121	$6,376	$6,376
3	$6,113	$6,435	$6,756	$7,078	$7,400	$7,721	$8,043	$8,043
4	$7,380	$7,768	$8,156	$8,545	$8,933	$9,322	$9,710	$9,710
5	$8,646	$9,101	$9,556	$10,011	$10,466	$10,922	$11,377	$11,377
6	$9,913	$10,435	$10,956	$11,478	$12,000	$12,522	$13,043	$13,043
7	$11,180	$11,768	$12,356	$12,945	$13,533	$14,122	$14,710	$14,710
8	$12,446	$13,101	$13,756	$14,412	$15,067	$15,722	$16,377	$16,377
9	$13,713	$14,435	$15,156	$15,878	$16,600	$17,322	$18,043	$18,043
10	$14,980	$15,768	$16,557	$17,345	$18,133	$18,922	$19,710	$19,710
Client Liability:	$45	$50	$55	$60	$65	$70	$75	Full Fee

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GRIEVANCE AND APPEAL PROCESS

If an individual has concerns, complaints, or problems with a decision made by the Dauphin County Department of Drug and Alcohol Services, the individual may contact the department regarding resolution of the identified issues.

Individuals may grieve the following four (4) issues:

1. Denial or termination of services
2. Level of care determination
3. Length of stay in treatment
4. Violation of human or civil rights

The grievance and appeal procedure once initiated is as follows:

1. An aggrieved individual may appeal in writing to the Grievance Review Board which is made up of agency staff including case management, prevention, and administrative personnel. The Grievance Review Board will make a decision about the grievance within seven (7) days and will notify the individual and the Department of Drug and Alcohol Programs in writing using the DDAP Grievance and Appeal Reporting Form. No client identifying information will be included or attached to the grievance and appeal form.

2. If the individual is not satisfied with the resolution by the Grievance Review Board, the individual can appeal to an independent panel consisting of three to five people and may include Dauphin County Drug and Alcohol Advisory Board members, a drug and alcohol case manager from another SCA, and/or a person in recovery. No one on this panel may have financial or contract ties to the Dauphin County Department of Drug and Alcohol Services. The individual will be asked to sign appropriate consent forms to permit release of information related to the case for the purpose of review as it pertains to appeal. The panel will make a decision about the appeal within seven (7) days and both the individual and the Department of Drug and Alcohol Programs will be advised of the outcome using the DDAP Grievance and Appeals Reporting Form.

- The individual has the right to have access to all documentation pertaining to the resolution of the grievance within the confines of state and federal confidentiality regulations.
- The individual has the right to be involved in the process and have representation by means of an advocate, case manager, or any other individual chosen by the individual at each level of appeal.
- If the appeal is related to termination of funding for or the reduction of treatment services, including treatment with Medications for Opioid/Alcohol Use Disorder, the individual shall continue to be funded for services at the current level of engagement until the appeal is resolved.

My signature below indicates I have read, and/or had read to me, the information above:

_____ _____
Client Signature Date

_____ _____
Witness Signature Date

I have been offered a copy of this document. Please initial: Accepted ( ) Declined ( )

Revised 6/2023

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RELEASE OF INFORMATION FORM

CLIENT NAME: _____SS#: _____DOB: _____

I voluntarily give my consent to the Dauphin County Department of Drug and Alcohol Services to *release* information to the following individual or agency:

_____
(Name of individual/Agency)

Information released will be limited to the following:

_____ Whether the client has relapsed into abuse and
Frequency of such relapse **___ The nature of the project**
_____ Prognosis/Diagnosis of the Client
_____Description of the client's progress
_____ Substance Abuse History and Demographics
_____Whether the client is or is not in treatment
_____ Other (Specify): _____

For the purpose(s) of:

_____Referral for Treatment Services
_____ To monitor the provision of ongoing treatment
_____To enable judges, attorneys, probation/parole officers to support treatment goals and/or make legal decisions on the client's behalf
_____To obtain insurance, employment or government benefits
_____Referral to intensive case management or other support services
_____Other (Specify): _____

I have read this form or had it explained to me and I understand its contents.

_____ _____
Signature of Client **Date** **Signature of Witness** **Date**

1 year after discharge from D&A Case Management (Specify date, event, or conditions pertinent to the situation)
Expiration Date

I have been offered a copy of this document. Accepted ( ) Declined ( )

I understand that the above information has been disclosed for records whose confidentiality is protected by Federal and State Regulations. (Federal Law 42 CFR Part 2, HIPAA Law of 1996, PA Code 255, PA Code 257, & Act 63). Federal Regulations (42 CFR Part 2 and HIPAA Law of 1996) prohibit any further disclosure, unless disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization of the release of medical or other information is not sufficient.
I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance of my consent. Also, I understand that in order to revoke my consent a request may be made verbally and/ or in writing to any Dauphin County Department of Drug and Alcohol Services staff member.

The agency or individual to whom information is sent is prohibited from re-disclosing this information to another party without my consent.

Rev. May 2023

Dauphin County

Department of Drug and Alcohol Services
1100 S. Cameron Street, Harrisburg, PA 17104
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Acknowledgement of Case Management Services

Dauphin County Department of Drug and Alcohol Services (SCA) provides Case Management Services to Dauphin County residents with a substance use disorder. The goals of Case Management are to increase engagement in and completion of substance use disorder treatment and to increase access to additional support services to assist in the recovery process. All individuals receiving SCA funding will be, at a minimum, within Administrative Case Management Services.

Administrative Case Management Services – SCA staff will provide follow-up and coordination of substance use disorder treatment for individuals who are funded by Dauphin County Drug and Alcohol Services. A Case Management Service Plan will be completed at the initial intake by Dauphin County Drug & Alcohol or one of Dauphin County Drug and Alcohol's contracted providers. Case Management staff will contact these individuals every sixty (60) days to review progress in treatment and evaluate if any nontreatment needs exist. The Case Management Service Plan will be updated during each contact every 60 days. At a minimum, phone contact must be maintained bimonthly between the Case Manager and the individual.

Discharge from Dauphin County Case Management Services will occur if individuals are no longer receiving funding from the Dauphin County SCA, relocate outside of Dauphin County, or if no contact could be maintained for more than thirty (30) days.

The individual understands that signing this Acknowledgment indicates that he/she has read or has had it read to him/her.

_____

Individual Signature Date

_____

Witness Signature Date

DDAP-EFM-1008 Rev. 1/16

pennsylvania
DEPARTMENT OF DRUG AND ALCOHOL PROGRAMS

Case Management Service Plan

Provider Location: _____

Provider Name: _____

DDAP License #: _____

UCN: _____ Date: _____

First Name: _____ M.I.: ____ **Last Name:** _____ Suffix: ---------

For each of the following areas, please indicate the individual's need(s) and recommended level(s) of assistance.

Need	Area of Assistance	Date Consent Completed
☐	**HEALTHCARE COVERAGE -** i.e. MA, Healthcare Market Place, Veteran's Benefits, etc.	
Comments:	**Action Step:**	
	60 Day Update:	
	120 Day Update:	
☐	**BASIC NEEDS -** i.e., assistance with meeting basic needs such as food, clothing, and transportation, assistance with getting client into a healthy recovery environment, referral to housing agencies, etc.	
Comments:	**Action Step:**	
	60 Day Update:	
	120 Day Update:	
☐	**PHYSICAL HEALTH -** i.e., medication management, pressing medical issues needing attention, pregnancy testing, pre-natal care, TB assessment, HIV/AIDS, Hepatitis, etc.	
Comments:	**Action Step:**	
	60 Day Update:	
	120 Day Update:	
☐	**EMOTIONAL/MENTAL HEALTH -** i.e., mental health referral, psychotropic medication management; co-occurring referral, etc.	
Comments:	**Action Step:**	
	60 Day Update:	
	120 Day Update:	
☐	**FAMILY -** i.e., counseling, education, resources, etc.	
Comments:	**Action Step:**	
	60 Day Update:	
	120 Day Update:	

Need	Area of Assistance	Date Consent Completed
☐	**CHILD CARE -** i.e., assisting client with: child custody/visitation and/or childcare arrangements, etc.	
Comments:	**Action Step:**	
	60 Day Update:	
	120 Day Update:	
☐	**LEGAL STATUS -** i.e., referral for legal assistance, communication skills when dealing with probation/ parole, etc.	
Comments:	**Action Step:**	
	60 Day Update:	
	120 Day Update:	
☐	**EDUCATION /VOCATION -** i.e., GED, tutoring, English as a Second Language (ESL) Office of Vocational Rehabilitation (OVR) etc.	
Comments:	**Action Step:**	
	60 Day Update:	
	120 Day Update:	
☐	**LIFE SKILLS -** i.e., assistance with cooking, cleaning, grocery shopping, paying bills in a timely manner, etc.	
Comments:	**Action Step:**	
	60 Day Update:	
	120 Day Update:	
☐	**SOCIAL -** i.e., develop healthy leisure activities, develop social skills, etc.	
Comments:	**Action Step:**	
	60 Day Update:	
	120 Day Update:	
☐	**EMPLOYMENT -** i.e., job search assistance, job training, résumé writing, Career Link, etc.	
Comments:	**Action Step:**	
	60 Day Update:	
	120 Day Update:	

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GPRA Follow Up Interviewer Locator Form

(Only for individuals with Opiate and Stimulant Disorders – Please see Stimulant list below):

Stimulant List: Crack/Cocaine, Methamphetamine, Amphetamines

A GPRA is a data collection tool that allows the federal government to better link resources and make decisions to serve individuals struggling with substance use disorders. Participation in follow up GPRA interviews helps to ensure continued funding of treatment services for individuals with opiate and stimulant use disorders.

Name:	
Phone Number:	**Okay to leave a message?**
Alternative Phone Number:	**Okay to leave a message?**
Email:	**Okay to leave a message?**

Alternative Contact Person:	
Phone Number:	**Okay to leave a message?** **Appropriate Release Signed?**
Alternative Contact Person:	
Phone Number:	**Okay to leave a message?** **Appropriate Release Signed?**

***I understand this information will be used by the SCA to assist in contacting me for a follow up interview.**

Individual's Signature: _____

OR

***I do not wish to give additional locator information at this time.**

Individual's Signature: _____

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GPRA LOCATOR RELEASE OF INFORMATION – This form is only to be completed if the individual added a contact to their GPRA Locator Form and wants that contact reached by Dauphin County Drug & Alcohol.

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RELEASE OF INFORMATION FORM

CLIENT NAME: _____SS#: _____DOB: _____

I voluntarily give my consent to the Dauphin County Department of Drug and Alcohol Services to *release* information to the following individual or agency:

_____
(Name of individual/Agency)

Information released will be limited to the following:

_____Whether the client has relapsed into use and Frequency of such relapse
_____ The nature of the project
_____Prognosis/Diagnosis of the Client
_____Description of the client's progress
_____ Substance Use History and Demographics
_____ Whether the client is or is not in treatment
__X____ Other (Specify): GPRA status and need to contact_____

For the purpose(s) of:

_____Referral for Treatment Services
_____To monitor the provision of ongoing treatment
_____To enable judges, attorneys, probation/parole officers to support treatment goals and/or make legal decisions on the client's behalf
_____To obtain insurance, employment, or government benefits
_____Referral to intensive case management or other support services
___X__Other (Specify): Locate individual for GPRA interview_____

I have read this form or had it explained to me and I understand its contents.

_____ _____
Signature of Client Date **Signature of Witness Date**

1 year after discharge from D&A Case Management
Expiration Date

I have been offered a copy of this document. Accepted ( ) Declined ( )

I understand that the above information has been disclosed for records whose confidentiality is protected by Federal and State Regulations. (Federal Law 42 CFR Part 2, HIPAA Law of 1996, PA Code 255, PA Code 257, & Act 63). Federal Regulations (42 CFR Part 2 and HIPAA Law of 1996) prohibit any further disclosure, unless disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization of the release of medical or other information is not sufficient.
I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance of my consent. Also, I understand that in order to revoke my consent a request may be made verbally and/ or in writing to any Dauphin County Department of Drug and Alcohol Services staff member.
The agency or individual to whom information is sent is prohibited from re-disclosing this information to another party without my consent.