CONSENT FOR THE RELEASE
OF CONFIDENTIAL INFORMATION

I, _____ authorize
(Name of patient)

_____,
(Name or general designation of alcohol/drug program making disclosure)

to disclose to _____,
(Name of person or organization to which disclosure is to be made)

the following information:

_____
(Nature and amount of information to be disclosed, as limited as possible)

_____

The purpose of the disclosure authorized in this consent is to:

_____
(Purpose of disclosure, as specific as possible)

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Pts. 160 & 164 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:

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

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form. Dated: _____

_____ _____
Signature of patient Signature of person signing form if not patient

Describe authority to sign on behalf of patient _____