

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____, authorize _____
(Name of Patient) (Name of alcohol/drug program making disclosure)

to: __disclose to, __request from, or __exchange with:

(Name of person and/or organization to which disclosure is to be made)

the following information: _____

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

The purpose of this disclosure is to: _____

(Purpose of disclosure, as specific as possible)

I understand that my records are protected under the Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, 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 will terminate automatically as follows:

(Specific date, event, or condition upon which consent expires)

Date Signature of Patient Printed Name of Patient

Date Signature of Parent, Guardian or Authorized Representative, when required Printed Name of Parent, Guardian or Authorized Representative, when required

Date Signature of Witness Printed Name of Witness