NAME/MRN

ALCOHOL AND OTHER DRUG SERVICES

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, , authorize

(Client Name) (Name or general designation of alcohol/drug program permitted to make the disclosure)

(Street Address, Phone Number and Fax Number of authorized Name or general designation of alcohol/drug program permitted to make the disclosure)

To disclose information to:

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

(Street Address, Phone Number and Fax Number of Name of person or organization to which the disclosure is to be made)

The following information:

(Nature AND amount of information to be exchanged, as limited as possible)

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

(Purpose of the 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 by the regulations. I also understand that I may revoke this consent, in writing, 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:

Date Which Consent Expires: *(if no date is specified this consent expires upon discharge from the treatment program or one year from the date it was signed, whichever occurs first)*: ________________

If applicable, please specify event or condition upon which this consent may also expire:_____________
____

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 understand that I have a right to receive a copy of this authorization upon request.

I have been offered a copy of this form. ☐**Yes** ☐**No**
I have accepted a copy of this form. ☐**Yes** ☐**No** Client Initials: _____________

___________________________	___________________________	__________
Printed Name of Client	**Signature of Client**	**Date**
___________________________	___________________________	__________
Printed Name of Staff	**Signature of Staff**	**Date**