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Consent for Release of Information

I, _____, born _____, authorize:
Client's Full Name

Releasing Agency or Individual

to release/receive information regarding my treatment to/from:

Receiving Agency or Individual

The information is to be limited to:

- | | |
|---|--|
| <input type="checkbox"/> Medical Records | <input type="checkbox"/> Psychological Testing/ Assessment |
| <input type="checkbox"/> Medication Information | <input type="checkbox"/> Alcohol and Drug Testing |
| <input type="checkbox"/> Treatment Compliance | <input type="checkbox"/> Mental Health Status |
| <input type="checkbox"/> Other: _____ | |

The information is to be used for: **Continuity of Care**

I understand that my records are protected under federal confidentiality regulations (and also regulation 42, CFR Part 2, "Confidentiality of Alcohol and Drug Abuse Patient Records") and cannot be disclosed without 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 (e.g. probation, parole, worker's compensation determination, etc.), and that this consent expires automatically upon (date, event, condition): _____, or one year from the date listed below.

By signing below, I acknowledge that the information to be released was fully explained to me, and that this consent is given of my own free will.

Client/ Guardian Signature

Date

Witness Signature

Date

Notice to Whom Information is given: The information disclosed by this authorization comes from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making further disclosure of it without specific written consent from the person to whom it pertains.