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AUTHORIZATION TO RELEASE AND OBTAIN CONFIDENTIAL INFORMATION

This form allows, with your permission, the facility involved in your care to communicate information that may be important to your evaluation, treatment and aftercare. Information may be communicated via telephone, written correspondence, facsimile, or email.

I, ***Date of Birth*** _____ ***Social Security*** _____
(Print Name)
hereby give permission to release or obtain the specific information or documents indicated below:

RELEASING INFORMATION TO AND OBTAIN FROM: (Must be Complete to be Valid)

Name: _____
Address: _____
Phone: _____
Fax: _____
Email: (if applicable) _____

The Information to be Released is: (Check Those Which Apply)

- ☒ Verbal and/or written report of psychiatric information, including data pertaining to alcohol or drug abuse.
- ☐ Verbal and/or written recommendations regarding return to work.
- ☒ Verbal and/or written report of laboratory or other testing results.
- ☒ Verbal and/or written report of medical information.
- ☒ Verbal and/or written report of participation and status/progress in the program.
- ☐ Other: _____

This Information will be Released for the Purpose of:

- ☒ Evaluation
- ☒ Treatment Planning
- ☐ Return to Work/School
- ☐ Other: _____

This consent will expire 12 months from the date of release: _____

☐ Restrictions on timeframe:_____

☐ Restrictions on mode of communication: _____

STATEMENT OF REVOCATION. TIME IN EFFECT. AND AUTOMATIC EXPIRATION OF RELEASE: I fully understand that I may, at any time, revoke this authorization for disclosure of information. If I choose to revoke this authorization, I will do so in writing. If not previously revoked, this consent will terminate as described above.

PROHIBITION ON RE-DISCLOSURE: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2, Sec. 2.31). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 and/or 45 CFR Parts 160 & 164). A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____ _____
Client Signature **Date**

_____ _____
Witness Signature **Date**