

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, of _____
(Name of patient/client) *(Patient/client address)*

authorize _____ to disclose to
(Custodian of information)

(Name, title, and organization to which disclosure is to be made)

The following information: _____
(Specific information to be disclosed)

for the follow purpose(s): _____
(Reason for disclosure)

I understand that my records are protected und Federal and State confidentiality laws and regulations and cannot be disclosed without my written authorization unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) this authorization at any time, except to the extent that action has been taken in reliance on it, and that in any event this authorization automatically expires as described below:

(Date, event, or condition upon which this authorization will expire)

I further acknowledge that the information to be released was fully explained to me and that this authorization is given of my own free well.

Executed this, the _____ day of _____, 20__

This authorization includes
 does not include information placed on my records after
the above date.

(Signature of patient/client)

(Signature of parent/guardian, where required)

(Signature of person authorized to sign in lieu of parent)

NOTE WHERE INFORMATION ACCOMPANIES THIS DISCLOSURE FORM: This information has been disclosed to you from records protected by Federal Confidentiality of Alcohol or Drug Abuse Patient Records rules (42 CFR part 2.) 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. 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.