Consent for the Release of Confidential Information

Client Name (Last, First, MI)	ID#

I, _____, authorize
(name of client)

_____
(name of program making the disclosure)

to disclose to _____
(person or organization to whom disclosure is to be made)

the following information: _____
(nature of information, as limited as possible)

Purpose of the disclosure is to: _____
(purpose of 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., Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in 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:

_____
(specification of the date, event or condition upon which this consent expires)

I understand that, generally, this agency may not condition my treatment on whether I sign a consent form, but that, in certain limited circumstances, I may be denied treatment if I do not sign a consent form.

Client Signature	Date
Parent or Guardian Signature	Date
Witness Signature	Date

Revocation of Consent

Client Signature	Date Revoked