Substance Abuse Record Release Consent Form

Notice to Receiver of Information: This information has been disclosed to you from records protected by Federal confidentiality 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.

Patient Information

Patient Full Name:

Date of Birth (MM/DD/YYYY):

Phone Number:

Address:

Authorization to Release Information

I hereby authorize the following facility/organization to disclose my substance abuse treatment records:

Releasing Facility/Organization Name:

Please release my records to the following recipient:

Recipient Name / Organization:

Recipient Address:

Recipient Phone / Fax:

Scope of Information to be Disclosed

Specify the exact information, dates, or types of substance abuse records to be disclosed (e.g., intake assessment, treatment plans, progress notes, discharge summary):

Records to be Disclosed:

Purpose of Disclosure

The purpose of this disclosure is (e.g., continuation of care, legal proceedings, personal use):

Purpose:

Expiration and Revocation

This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate/expire upon the following date, event, or condition:

Expiration Date, Event, or Condition:

Acknowledgment and Signatures

By signing below, I understand that my substance abuse treatment records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Pts. 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

Signature of Patient (or Authorized Representative):

Date Signed (MM/DD/YYYY):

If signed by a Representative, state relationship to Patient: