Consent for Release of Information

CONSENT FOR RELEASE OF INFORMATION

I,_____, BORN ON_____,
(PATIENT NAME) (PATIENT BIRTH DATE)

AUTHORIZE_____TO
(CLINIC OR PROVIDER'S NAME)

DISCLOSE TO _____
(NAME AND LOCATION OF PERSON/ORGANIZATION TO RECEIVE INFORMATION)

THE FOLLOWING INFORMATION:_____.

THE PURPOSE OF THIS DISCLOSURE IS:_____.

THIS AUTHORIZATION EXPIRES ON:_____, OR

WHENEVER_____IS NO LONGER PROVIDING ME WITH SERVICES.

I understand that my records are protected under the Federal regulations and cannot be disclosed without my 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.

Signature of patient_____Dated _____

Signature of witness_____Dated _____

ATTENTION RECIPIENT:
Notice Prohibiting Re-disclosure

This information has been disclosed to you from the records protected by Federal confidentiality rules (42 C.F.R. 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 C.F.R. 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 this information to criminally investigate or prosecute any alcohol or drug abuse patient.