CONSENT FOR RELEASE OF INFORMATION

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

SSN_____, AUTHORIZE_____TO
(PATIENT SOCIAL SECURITY #) (CLINIC OR DOCTOR'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.

CONFIDENTIALITY OF SUBSTANCE USE DISORDER PATIENT RECORDS

THE CONFIDENTIALITY OF SUBSTANCE USE DISORDER PATIENT RECORDS MAINTAINED BY THIS PRACTICE/PROGRAM IS PROTECTED BY FEDERAL LAW AND REGULATIONS. GENERALLY, THE PRACTICE/PROGRAM MAY NOT SAY TO A PERSON OUTSIDE THE PRACTICE/PROGRAM THAT A PATIENT ATTENDS THE PRACTICE/PROGRAM, OR DISCLOSE ANY INFORMATION IDENTIFYING A PATIENT AS HAVING OR HAVING HAD A SUBSTANCE USE DISORDER UNLESS:

1. THE PATIENT CONSENTS IN WRITING;
2. THE DISCLOSURE IS ALLOWED BY A COURT ORDER, OR
3. THE DISCLOSURE IS MADE TO MEDICAL PERSONNEL IN A MEDICAL EMERGENCY OR TO QUALIFIED PERSONNEL FOR RESEARCH, AUDIT, OR PRACTICE/PROGRAM EVALUATION.

VIOLATION OF THE FEDERAL LAW AND REGULATIONS BY A PRACTICE/PROGRAM IS A CRIME. SUSPECTED VIOLATIONS MAY BE REPORTED TO APPROPRIATE AUTHORITIES IN ACCORDANCE WITH FEDERAL REGULATIONS. THE REPORT OF ANY VIOLATION OF THESE REGULATIONS MAY BE DIRECTED TO THE ATTORNEY GENERAL FOR YOUR STATE.

FEDERAL LAW AND REGULATIONS DO NOT PROTECT ANY INFORMATION ABOUT A CRIME COMMITTED BY A PATIENT, EITHER AT THE PRACTICE/PROGRAM OR AGAINST ANY PERSON WHO WORKS FOR THE PRACTICE/PROGRAM OR ABOUT ANY THREAT TO COMMIT SUCH A CRIME.

FEDERAL LAWS AND REGULATIONS DO NOT PROTECT ANY INFORMATION ABOUT SUSPECTED CHILD ABUSE OR NEGLECT FROM BEING REPORTED UNDER STATE LAW TO THE APPROPRIATE STATE OR LOCAL AUTHORITIES.

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	Date
Signature of parent/guardian/authorized signer (if applicable)	Date
Signature of witness	Date

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 patient with alcohol or drug use disorder.

After completion, scan form into patient record and provide a copy to the patient.