FORM 1
SAMPLE CONSENT FORM

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, ____________________________________________, authorize

(Name of patient)

(Name or general designation of alcohol/drug program making disclosure)

to disclose to ____________________________________________ the

(Name of person or organization to which disclosure is to be made)

following information: ____________________________________

(Nature and amount of information to be disclosed; as limited as possible)

The purpose of the disclosure authorized in this 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 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. pts 160 & 164, and
cannot be disclosed without my written consent unless otherwise provided
for by 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,
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 I might be denied services if I refuse to consent to a
disclosure for purposes of treatment, payment, or health care operations,
if permitted by state law. I will not be denied services if I refuse to consent
to a disclosure for other purposes.

I have been provided a copy of this form.

Dated: ________________  ________________________________

Signature of Patient

Signature of person signing form if not patient

Describe authority to sign on behalf of patient ________________________________