

Information Release Authorization Form

I, _____,
(Name of Client)

Authorize, _____,
(Name or general designation of program making discloser)

To disclose to _____
(Name of person or organization to which discloser is to be made)

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

I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, 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 anytime 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)

(Date)

(Signature of Participant)

(Signature of parent, guardian, or authorized representative, if required.)