

MEDICAL RECORDS RELEASE

I, _____
(client/parent/legal guardian)

for _____ DOB: _____ authorize:
(self/child)

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___ To **RELEASE** information described to:

___ To **OBTAIN** information described below from:

Individual/Agency: _____

Phone: _____ Fax: _____

Specific Information to be released _____

___ Records of substance abuse ___ Records of HIV/AIDS diagnosis/testing

Purpose for disclosure _____

The information is being release by means of (check all the apply):

___ Copy of Records ___ Written Report ___ Telephonic communication/staffing

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFT Prt 2 and Title 42, Chapter 1, Volume 40, #27, Part IV, and cannot be disclosed without my written consent unless otherwise provided for these 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 shall expire **one year** from the date signed.

Client/Parent/Legal Guardian Signature

Date

Witnessed By

Date