CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

1. _____ AUTHORIZE THE FOLLOWING DISCLOSURE OF INFORMATION FROM MY TREATMENT RECORD:

2. NAME OF PROGRAM WHICH IS TO MAKE THE DISCLOSURE: _____
_____

3. NAME OR TITLE OF PERSON OR ORGANIZATION TO WHICH THE DISCLOSURE IS TO BE MADE: _____
_____

4. PURPOSE OR NEED OF DISCLOSURE: _____
_____

5. EXTENT OR NATURE OF INFORMATION TO BE DISCLOSED: _____
_____

6. DATE OF BIRTH _____

7. THIS CONSENT IS SUBJECT TO REVOCATION AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE THEREON. IF NOT PREVIOUSLY REVOKED, THIS CONSENT WILL TERMINATE UPON (SPECIFIC DATE, EVENT, OR CONDITION):
_____

8. SIGNATURE OF PATIENT: _____

SIGNATURE OF PARENT OR GUARDIAN: _____

SIGNATURE OF PERSON AUTHORIZED TO SIGN IN LIEU OF THE PATIENT (WHERE REQUIRED): _____

9. DATE ON WHICH THIS CONSENT IS SIGNED _____

I understand that my records are protected under the Federal and State confidentiality 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 (e.g. probation, parole, etc.) and that in any event this consent expires automatically as described above.