

Name/Practice Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, ZIP: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

## CONSENT TO RELEASE/RECEIVE CONFIDENTIAL INFORMATION

I, \_\_\_\_\_, authorize \_\_\_\_\_ at the above address to:  
Patient Name (Print) Physician Name (Print)

### MD check all that apply

- Receive my medical history information from the following physicians:  
(name, address) \_\_\_\_\_  
(name, address) \_\_\_\_\_
- Receive my treatment records from the following therapist:  
Therapist (name, address) \_\_\_\_\_
- Release my treatment information/records to the following healthcare professional:  
(name, address) \_\_\_\_\_
- Release my treatment information to the health insurance company listed below, for billing purposes:  
Insurance Provider (name, address) \_\_\_\_\_  
\_\_\_\_\_

This information is for the following purposes (any other use is prohibited): \_\_\_\_\_  
\_\_\_\_\_

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken on reliance on it. This consent will last while I am being treated for opioid dependence by the physician specified above unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

**I understand that the records to be released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.**

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Parent/Guardian Name (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Witness Name (Print)

\_\_\_\_\_  
Date

### **Confidentiality of Alcohol and Drug Dependence Patient Records**

The confidentiality of alcohol- and drug-dependence 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 being alcohol- or drug-dependent 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.

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 appropriate state or local authorities.