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Authorization for Release of Information

I, _____, hereby authorize
to release information about me to, and obtain information from, the following individual(s)/organization:

Name_____

Address_____

Phone/fax_____

E-mail_____

The specific information pertaining to me and to my treatment to be released is (please check all that apply)

___Treatment records
___Treatment summary
___Verbal information exchange
___E-mail information exchange
___Other

The purpose for which this information is being released is

___Insurance payment
___Enhancement of my treatment
___Custody evaluation
___Legal deposition/court testimony
___Magazine article
___Other

I understand that this authorization may include disclosures of alcohol and Drug Abuse records which are protected by the provisions of Federal Regulations 42 C.R.F., part 2.

This authorization is valid for/until _____.

I understand that I have the right to revoke this authorization at any time.

_____ date_____
signature of patient

_____ date_____
signature of parent or guardian

printed name_____