

AUTHORIZATION AND CONSENT FOR RELEASE OF INFORMATION

I, _____, authorize and request the Tallapoosa Circuit Drug Intervention Program to obtain/release records to/from _____
(Name & address of person or agency to release/receive records.)

all information regarding _____, DOB _____,
(Participants Name)

Social Security Number _____ - _____ - _____, From _____ to _____.
(Date) (Date)

Reason for disclosure: _____.

Information to be disclosed: Laboratory Work Drug Screens TB Skin Test Results

Evaluation/Assessment/Diagnosis Dates of Treatment History and Physical

Discharge Summary Continuing Care Plan Progress Notes Other _____

This authorization and consent is subject to revocation at any time, except to the extent that the Tallapoosa Drug Intervention Program has already taken action in reliance on it. If not previously revoked, this authorization will remain in effect until final disposition of this case, but not to exceed (5) years from this date.

Any Disclosure made is bound by Part 2 of Title 42 of the Code of Federal Regulations governing confidentiality of AOD abuse patient records and that recipients of this information may disclose it only in connection with their official duties.

Signature of Participant Date Witness Date

NOTICE TO RECIPIENT

THE INFORMATION THAT HAS BEEN DISCLOSED TO YOU IS PROTECTED BY STATE AND FEDERAL LAW. YOU ARE PROHIBITED FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER AUTHORIZATION IS OBTAINED OR DISCLOSURE IS OTHERWISE PERMITTED BY LAW. A GENERAL AUTHORIZATION FOR RELEASE OF INFORMATION MAY NOT BE SUFFICIENT.

The information requested was released to _____

on the _____ day of _____, 200__ by _____.