Interagency Consent to Release Substance Abuse Confidential Information

I, _____, of _____
(Name of Client) (Client's Address)

authorize _____ to disclose to
(Custodian of Information)

_____
(Name, Title and Organization to whom disclosure is to be made)

the following information: related to the assessment, diagnosis and treatment of substance abuse specific information for the following purpose(s): Interagency service planning.

I understand that my records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) 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 automatically expires as described below:

When FAPT involvement ends. Or Other dates: _____

I further acknowledge that the information to be released was fully explained to me and that this consent is given of my own free will.

Executed this _____ day of _____, 20_____.

This consent includes information placed on my records after the above date.

_____
Signature of Client

_____
Signature of Parent/Guardian (where required)

NOTE WHERE INFORMATION ACCOMPANIES THIS DISCLOSURE FORM: This information has been disclosed to you from records protected by Federal Confidentiality of Alcohol or Drug Abuse Patient Records rules (42 CFP part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.