CM COUNSEL

AUTHORIZATION TO DISCLOSE/OBTAIN RECORDS

Patient Name:_____ Date of Birth:_____

Patient Social Security Number:_____

Information **Released** to:_____

Address:_____

_____

Information **Obtained** from:_____

Address:_____

_____

Specific Information **Released/Obtained:**

_____

_____

I understand that my records are protected by the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42CFR Part 2), and cannot be disclosed without my written consent unless otherwise provided for in state or federal 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, and that in any event this consent expires as follows:

Specification of date, event, or condition expires:

_____

_____

I, _____ hereby authorize_____ of CM Counsel to either **release or obtain** the information stated above.

Patient/ Parent/ Legal Guardian

Signature_____ Date:_____

Witness:_____ Date:_____

Prohibition on Redisclosure:
Alcohol and Drug Abuse information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosures of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such legislation. 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.

COPY OF RELEASE OFFERED TO PATIENT: ACCEPTED_____ REJECTED___