

SUBSTANCE ABUSE REHABILITATION PROGRAM

INFORMATION RELEASE AUTHORIZATION

I, _____ hereby authorize _____,
(patient's name) (program name)

its director or designee, to release information contained in my treatment records to the individuals or organizations and only under the conditions listed below:

1. Name of person(s) or organization(s) to whom disclosure is to be made: _____

2. Specific type of information to be disclosed: _____

3. The purpose and need for such disclosure: _____

4. This consent is subject to revocation at any time.

5. Without expressed revocation this consent expires for the following specified reasons:

a. Date: ___ / ___ / ___

b. Event: _____

c. Condition: _____

Witnessed By

Patient Signature

Date Witnessed

Date Signed

Patient Name	Rank/Grade	Sex
SSN/Identification Number	Status	Date of Birth
Branch of Service	Organization	
Sponsor's Name	Relationship to Sponsor	