

BEHAVIORAL HEALTH & SUBSTANCE ABUSE NETWORK, Inc (BHSAN)

Consent for Release of Confidential Information

I, _____ authorize
(Name of patient)

_____ to disclose to
(Name of general designation of program making disclosure)

_____ to which disclosure is to be made)

the following information:

(Nature of the information, as limited as possible).

The purpose of the disclosure authorized herein is to:

(Purpose of disclosure, as specific as possible).

I understand that my records are protected under federal regulations governing the HIAPP Privacy Rule and the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the 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 automatically as follows:

(Specification of the date, event, or condition upon which this consent expires)

Dated _____

Signature of
participant _____

(Signature of parent, guardian, or authorized representative when required)"