Any Agency
CONSENT TO RELEASE AND EXCHANGE OF INFORMATION

I, _____, hereby authorize **Any Agency** to request and/or
(PARENT/GUARDIAN OF CLIENT OR CLIENT NAME)
disclose information, verbal or written, of _____
(NAME OF CLIENT)
to _____
(NAME OF AGENCY OR INDIVIDUAL – INCLUDE RELATIONSHIP) (CONTACT INFORMATION)

_____
(St Address) (City) (State) (Zip)

Please initial next to all applicable items requested below
The records requested are for the following services:

_____	☐	Substance/Alcohol Abuse Services	_____	☐	Mental Health Services
_____	☐	Case Management	_____	☐	HIV/AIDS Related Information
_____	☐	RSS Services (Other)	_____	☐	Legal Services

Please initial next to all applicable items requested below
Specific Information Requested:

_____	☐	GAIN Assessment	_____	☐	Admission/Discharge Summary
_____	☐	Psychiatric Evaluation	_____	☐	Court Related Information
_____	☐	Social/Medical History	_____	☐	Case Management Plans/Progress
_____	☐	History & Physical Exam	_____	☐	Treatment Plans
_____	☐	Laboratory Data (Drug Testing)	_____	☐	Probation/Parole Progress Reports
_____	☐	Admission/Discharge Summary	_____	☐	Exchange Information
_____	☐	Medication Records	_____	☐	Other _____

The purpose of the disclosure authorized herein is to:_____
(Purpose of disclosure, as specific as possible)

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, as well as the Health Information Portability and Accountability Act (HIPAA) of 1996, 45 CFR Parts 160 and 164 Subparts A and E, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent any time, by either written or verbal notification, except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically 365 days post-discharge from the treatment program

I also understand that this authorization is voluntary and that I may refuse to sign this authorization. I understand that this agency may not condition treatment, payment, enrollment or eligibility for benefits whether or not I sign this authorization, unless allowed by law. I understand that I may inspect or copy any information used or disclosed under this authorization.

Client Signature_____ Date_____

Parent/Guardian_____ Date_____

Agency Representative_____ Date_____