

CONSENT TO DISCLOSURE OF INFORMATION

IMPORTANT NOTICE: THIS CONSENT FORM IS AN AUTHORIZATION AND/OR A REQUEST FOR THE RELEASE OF INFORMATION. IT IS SUBJECT TO REVOCATION AT ANY TIME, EXCEPT TO THE EXTENT THAT THE ADOLESCENT SUBSTANCE ABUSE PROGRAM OR OTHER AGENCY NAMED BELOW HAS ALREADY TAKEN ACTION IN RELIANCE UPON IT.

1. I, _____

(INDICATE PATIENT AND/OR PARENT NAME)

HEREBY CONSENT TO THE DISCLOSURE HEREINAFTER DESCRIBED AND AUTHORIZE THAT IT BE MADE.

2. THE DISCLOSURE IS TO BE MADE BY:

THE ADOLESCENT SUBSTANCE ABUSE PROGRAM

(INDICATE SPECIFIC NAME OF PERSON OR PROGRAM DESIGNATION)

3. DISCLOSURE IS TO BE MADE TO:

THE ADOLESCENT SUBSTANCE ABUSE PROGRAM

(INDICATE SPECIFIC NAME OF PERSON OR PROGRAM DESIGNATION)

4. THE DISCLOSURE CONSISTS OF THE FOLLOWING INFORMATION CONCERNING THE PATIENT:

Any and all records of the evaluation and/or treatment for alcohol and other drug use, and other mental health conditions.

Other: _____

5. THE DISCLOSURE IS AUTHORIZED FOR THE FOLLOWING PURPOSE:

To facilitate Adolescent Substance Abuse Program evaluation and monitoring.

Other: _____

6. IF NOT PREVIOUSLY REVOKED, THIS CONSENT WILL TERMINATE UPON THE FOLLOWING DATE, EVENT OR CONDITION:

7. THIS CONSENT IS SIGNED ON _____

(signature of patient and/or parent) _____

(printed/typed name) _____