

**(Sample) Standard Authorization
To Disclose Substance Abuse Treatment Information**

I, _____ [Insert Name of Patient/Client], whose Date of Birth is _____,

authorize [Insert Name of Mental Health Counseling Organization] to disclose to and/or obtain from:

_____ the following information:
[Insert Name of Person or Title of Person or Organization]

Description of Information to be Disclosed

(Patient/Client should initial each item to be disclosed)

- | | |
|---|--|
| _____ Assessment | _____ Nursing/Medical Information |
| _____ Diagnosis | _____ Toxicological Reports/Drug Screens |
| _____ Psychosocial Evaluation | _____ Educational Information |
| _____ Psychological Evaluation | _____ Discharge/Transfer Summary |
| _____ Psychiatric Evaluation | _____ Continuing Care Plan |
| _____ Treatment Plan or Summary | _____ Progress in Treatment |
| _____ Current Treatment Update | _____ Demographic Information |
| _____ Medication Management Information | _____ Other _____ |
| _____ Presence/Participation in Treatment | _____ Other _____ |

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

If the purpose is other than as stated above, please specify:

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to [Insert Name] at [Insert Contact Information]. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires on the following date: _____ or as otherwise indicated: _____.

A copy of this form will be maintained for a period of six (6) years from this expiration date.

Conditions

I further understand that [Insert Name of Mental Health Counseling Organization] will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:

[Insert an explanation of the consequences, if any, of not signing this authorization, which will depend on the services being provided].

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. I will be given a copy of this authorization for my records.

Signature of Patient/Client Date

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____ Check here if patient/client refuses to sign authorization

Signature of Staff Witness Date