**CONSENT FOR THE RELEASE OF CONFIDENTIAL PSYCHIATRIC,   
ALCOHOL, OR DRUG TREATMENT INFORMATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(NAME OF PATIENT) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(BIRTHDATE)

authorize: David Kan, MD to disclose to:

the following information:

(NATURE AND AMOUNT OF INFORMATION TO BE DISCLOSED, AS LIMITED AS POSSIBLE)

The purpose of the disclosure authorized herein is to:

(PURPOSE OF DISCLOSURE, AS SPECIFIC AS POSSIBLE)

I understand that my alcohol and/or drug treatment records are protected under the federal

regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 Code of

Federal Regulations (CFR) Part 2, and the Health Insurance Portability and Accountability Act

of 1996 (HIPAA), 45 CFR, Parts 160 and 164, 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)

I understand that generally the alcohol and/or drug treatment program may not condition my

treatment on whether I sign a consent form, but that in certain limited circumstances I may be

denied treatment if I do not sign a consent form.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
DATED:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SIGNATURE OF PATIENT**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**SIGNATURE OF PARENT, GUARDIAN OR AUTHORIZED REPRESENTATIVE (WHEN REQUIRED)**

**NOTICE**

**PROHIBITING REDISCLOSURE**

**OF ALCOHOL OR DRUG TREATMENT INFORMATION**

**Prohibition on Redisclosure of**

**Confidential Information**

This notice accompanies a disclosure of information concerning a client in psychiatric/alcohol/drug treatment, made to you with the consent of such client.

This information has been disclosed to you from records protected by federal

confidentiality rules, 42 Code of Federal Regulations (CFR), Part 2. The

federal rules prohibit you from making any further disclosure of this

information unless further disclosure is expressly permitted by the written

consent of the person to whom it pertains or as otherwise permitted by 42

CFR, Part 2.

A general authorization for the release of medical or other

information is **NOT** sufficient for this purpose.

The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.