

**Authorization for Release of Protected**

**Health Information Form**

Name of Participant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

PRINT First Name PRINT Last Name Date

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, request that my substance abuse treatment information be (circle one) **RELEASED** **TO** or **RECEIVED** **FROM:**

|  |  |
| --- | --- |
| Name of Entity |  |
| Address |  |
| City, ST ZIP |  |
| Phone |  |
| Fax |  |
| Email |  |

For the purposes of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing this document, I hereby declare that I understand and acknowledge that I am giving authorization to the use and/or disclosure of my protected health information as described and for the purpose specified above.

I am signing this authorization voluntarily. I understand that I have the right to withdraw my permission or withdraw my authorization at any time by writing. In case I withdraw my authorization, I understand that any benefits, treatment, or eligibility shall not be affected.

Further, I understand that this authorization may not further be used by the person or entity to whom my medical records are to be disclosed, to use or disclose the said information to another unless otherwise permitted in writing or unless such intended disclosure is required or permitted by law.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff Witness Date