Authorization for Release of Substance Abuse Treatment Information

Patient Name:

Date of Birth:

Patient Address:

Phone Number:

I hereby authorize the release of my substance abuse treatment information as follows:
Released By (Name of Facility/Provider):

Released To (Name/Organization/Address):

Specific information to be released (check all that apply):

- ☐ Assessment/Evaluation
- ☐ Treatment Plan
- ☐ Progress Notes
- ☐ Discharge Summary
- ☐ Other (specify):

Purpose of Disclosure (check all that apply):

- ☐ Continuity of Care
- ☐ Legal
- ☐ Insurance
- ☐ Other (specify):

Dates of Service to be Released:

This authorization will expire on (date or event):

Patient Signature:

Date:

Relationship/Authority to sign (if not patient):

Notice: This form complies with federal confidentiality regulations (42 CFR Part 2) as well as applicable state laws. Re-disclosure of this information without further written consent of the person to whom it pertains is prohibited.

This Authorization for Release of Substance Abuse Treatment Information form sample is designed to facilitate the secure and legal sharing of sensitive treatment details between authorized parties. It ensures compliance with privacy regulations while allowing the necessary exchange of information for continued care or legal purposes. Using this form helps protect patient confidentiality and supports effective communication among healthcare providers.