



Phoenix Programs, Inc.

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____,

Authorize

name of general designation of person/program making the disclosure)

to disclose to

(name of person/program to whom disclosure is being made)

The following information: (List nature of information to be disclosed, be specific)

The purpose of the authorized disclosure is:(Be as specific as possible)

I Understand that my records are kept confidential by agency policy. For chemical dependency services, records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Client Records 42 CFR Part 2, and the Health Insurance Portability A Accountability Act of 1996 (HIPAA) and cannot be disclosed without written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time, but this would not cover disclosures that had previously been. Revocation must be accomplished per written request and may be for specific items or the entire release. This consent will automatically expire 1 year from date of signature, unless there is a different specification of date, event, or condition noted; _____

Signature of Client: _____

Date: _____

Signature of Witness: _____

Date: _____

Signature of Parent/Guardian/Legal Rep: _____ Date: _____

(Specify relationship to client (_____))