Substance Abuse Treatment Information Release

Client Information

Name

Date of Birth

Client ID (if applicable)

Recipient of Information

Name/Organization

Address

Phone/Fax

Purpose of Disclosure

Information to be Released

Expiration

This authorization will expire on

☐ I understand that my substance use records are protected under federal confidentiality regulations (42 CFR Part 2) and cannot be disclosed without my written consent unless otherwise permitted by law.

Client Signature

Date

Witness/Parent/Guardian (if required)

Date