Substance Abuse Treatment Records Release Form

Patient Name
Date of Birth
Address
Telephone
I authorize the release of my substance abuse treatment records:
From
To
Name/Organization
Traine Organization
Address
Telephone
Purpose of Disclosure
Turpess of Biosissairo
Information to be Disclosed
Other (specify)
Expiration Date or Event
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Additional Comments or Limitations
Patient Signature
Date
Witness Signature
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Date