Substance Abuse Treatment Records Release

Patient Information

Name

Date of Birth

Phone Number

Release Details

Release Substance Abuse Treatment Records **FROM** (Provider/Facility Name)

Provider/Facility Address

Provider/Facility Phone

Release records **TO** (Individual/Organization Name)

Recipient Address

Recipient Phone

Information to be Released

☐ Assessment/Evaluation

☐ Treatment Summary

☐ Progress Notes

☐ Discharge Summary

☐ Other (specify below)

If Other, specify

Purpose of Disclosure

Authorization Period

Effective Date

Expiration Date/Event

Patient Rights & Signature

I understand I may revoke this authorization at any time by notifying the provider in writing. This authorization is voluntary, and I understand that my treatment or payment for services will not be affected if I do not sign this form. I understand that information disclosed as a result of this authorization may be re-disclosed by the recipient and may no longer be protected by privacy laws.

Patient Signature

Date

If patient is a minor or lacks capacity, Representative's Name/Relationship

Representative Signature

Date