CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____, authorize _____

_____

(Name or general designation of alcohol/drug program permitted to make the disclosure)

To disclose information to: **SUPPORT4HOUSING (S4H is a component of Support4Recovery)**

_____

(Name of person or organization to which the disclosure is to be made)

The following information**: INTAKE AND DISCHARGE DATES, PROGRESS IN PROGRAM**

_____

(Nature AND amount of information to be exchanged, as limited as possible)

The purpose of the disclosure authorized in this consent is to:

ASSIST WITH HOUSING SUPPORT

(Purpose of the disclosure, as specific as possible)

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Pts. 160& 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent, in writing, at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

Date Which Consent Expires: *(if no date is specified this consent expires upon discharge from the treatment program or one year from the date it was signed, whichever occurs first):*

_____

If applicable, please specify event or condition upon which this consent may also expire:

_____

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by State law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I further understand that I have a right to receive a copy of this authorization upon request.

☐ **Yes** ☐ **No** Initial _____

_____ _____ _____

Printed Name **Signature of Client** **Date**