Consent for the Release of Confidential Information

_____

(Family member, counselor, attorney, probation officer, physician, etc.)

PLEASE ENTER ONLY ONE NAME ABOVE; A SEPARATE FORM MUST BE COMPLETED FOR EACH PERSON TO WHOM YOU ARE ALLOWING INFORMATION TO BE RELEASED

FULL RELEASE

☐ I authorize Columbia Addictions Center to release information to, and to obtain information from, the person or organization I have written above.

-OR-

LIMITED RELEASE

☐ I authorize Columbia Addictions Center to release ***only*** the following information to the person or organization I have written above:

_____Appointment dates/times

_____Account Balance

_____Initial Evaluation

_____Progress, Attendance and Discharge

_____Urinalysis or Breathalyzer results

Signed by: _____ _____

Signature of Patient or Legal Guardian Relationship to Patient

_____ _____

Print Patient's Name Date

This authorization will be valid for one year unless I otherwise specify.

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization.

Columbia Addictions Center
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Columbia, MD 21044