CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Please fill out all the following information.
A separate form must be filled for each person/organization.

I, _____, date of birth ____/____/____, authorize Columbia Treatment Center to release information to, and to obtain information from, the following person or organization:

Recipient's Name: _____

Recipient's Phone: _____

Recipient's Email: _____

The recipient is my (check one of the following):

☐ Attorney, ☐ Probation Officer, ☐ Counselor, ☐ Physician, ☐ Parent, ☐ Spouse

☐ Other/Please State: _____

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.

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