Consent for the release of confidential alcohol or drug treatment and HIV/AIDS information to comply with disease reporting requirements

Adapted from the Substance Abuse and Mental Health Services Administration (TAPS 13)

| I, ______________________________________________________________________________________________, authorize |
| (Name of Resident) |

| (Name or general designation of program making disclosure) |
| to disclose to ______________________________________________________________________________________________ |

| (Name or organization to which disclosure is to be made) |
|_________________________________________________________________________________________________________|

the following information:

1. **information that State law requires to be reported about my diagnosis and treatment for --**
   - [ ] HIV infection
   - [ ] AIDS

2. **my name and other personal identifying information, if required to be reported by State law; and**

3. **information about my status as a patient in alcohol or drug treatment, if required to be reported by State law.**

   The purpose of the disclosure authorized herein is to: ______________________________________________
   _______________________________________________________________________________________________

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that HIV-related information about me, STD-related information about me, and TB-related information about me is protected by State law and cannot be disclosed unless the disclosure is authorized by State law. I also understand that I may revoke this consent 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:

   ___________________________________________________________________________________________

   ____________________________________________________________________________________________

Dated: __________________________      Signature of resident: _____________________________________

I refuse to sign this document.

Signature of Resident (Parent/Guardian if client is minor) ______________________      Date ________________

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Sponsored by the Department of Public Health, Bureau of Substance Abuse Services
Facilitated by The Quality Improvement Collaborative