Consent for the Release of Confidential Alcohol or Drug Treatment Information
Developed by 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 of person or organization to which disclosure is to be made)
_________________________________________________________________________________________________________
the following information: ________________________________________________________________________
(Nature of the information, as limited as possible)
_________________________________________________________________________________________________________
_________________________________________________________________________________________________________
The purpose of the disclosure authorized herein is to: ________________________________________________
(Purpose of disclosure as specific as possible)

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 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:
_________________________________________________________________________________________
(Specification of the date, event, or condition upon which this consent expires)
_________________________________________________________________________________________________________
Dated: __________________________                    ___________________________________________
Signature of resident

Signature of parent, guardian or authorized representative when required