# Authorization to Disclose Information

**(Disclosure of the Social Security Number is optional and voluntary. It is requested for the purpose of accurate identification)**

| Client: | Social Security Number | Date of Birth | |
|---|---|---|---|
| Address | City | State | Zip code |

## I authorize:

| Person/Agency to Release Information | Address | | |
|---|---|---|---|
| City | State | Zip Code | Phone |

## To disclose information only if the recipient agrees to keep the information confidential, to:

| Person/Agency to Release Information | Address | | |
|---|---|---|---|
| City | State | Zip Code | Phone |

## Information to be disclosed: (Be specific)

## Information will be used for: (List each purpose)

Consideration/Development of an Individual Justice Plan and other supports and services.
Other:

## I authorize the disclosure of information between both listed parties to the extent necessary to obtain rights and services.

□ **Yes** □ **No** □ **Not Applicable**

## This authorization is in effect until: (Specify date OR event which ends this authorization)

## Client consent:

This authorization was not obtained as a condition of obtaining insurance coverage. This authorization is voluntary and I understand that I can revoke this authorization at any time by providing written notice to the involved parties. Any information disclosed before I revoke this authorization is not a breach of confidentiality. A photocopy of this authorization is as effective as the original. This authorization allows disclosure of information in any form.

I understand that information disclosed might be re-disclosed and no longer protected by federal law covering privacy of medical information (HIPPA). I explicitly require that anyone, who receives information pursuant to this authorization, must protect the information as confidential. Addiction records can be re-disclosed only as permitted by federal law (42 C.F. R. Part 2). I have received and understand the information regarding confidentiality.

**Signature: _____ Date: _____**

Check One: □ Client □ Guardian/Custodian □ Parent

Signature of Witness (If needed) _____

**Disclosure of Information - Addiction Records: (Please Check if Applicable)**

□ This information may be disclosed from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit further disclosure, unless further disclosure is expressly permitted by written consent of the person to whom it pertains, or as otherwise permitted by 42 C.F.R. Part 2. A general disclosure of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**Signature: _____ Date: _____**