



**CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION**

I, \_\_\_\_\_, authorize  
*(Name of Client)*

\_\_\_\_\_  
*(Person or organization to make disclosure)*

To disclose to/from:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

the following information: \_\_\_\_\_  
 \_\_\_\_\_

The purpose of the disclosure authorized herein is to facilitate treatment.

I understand that my alcohol and drug treatment records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records: Title 42 C.F.R Part 2 and the Health Insurance Portability and Accountability Act 1996 (HIPAA), Title 45 C.F.R. parts 160 and 164 in which can not be disclosed without written consent unless otherwise provided in the regulations.

I also understand that I may revoke this consent at any time in writing except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:  
90 days after discharge from Tahoe Youth and Family Services Program. Date: \_\_\_\_\_

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment and/or payment. I will not be denied services if I refuse to consent to a disclosure for other purposes.  
 I have been provided a copy of this form.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent(s) or Guardian of client: \_\_\_\_\_ Date: \_\_\_\_\_

Described authority to sign on behalf of Client: \_\_\_\_\_ Date: \_\_\_\_\_