



**CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION**

I,

\_\_\_\_\_  
*(Print client's first, Middle, last name)*

\_\_\_\_\_  
*(PAS ID)*

\_\_\_\_\_  
*(DOB)*

Hereby authorize Peer Assistance Services, Inc. to release information concerning me, to:

\_\_\_\_\_  
*Name of person or organization*

\_\_\_\_\_  
*Phone*

\_\_\_\_\_  
*Fax*

\_\_\_\_\_  
*Street Address*

\_\_\_\_\_  
*City*

\_\_\_\_\_  
*State*

\_\_\_\_\_  
*Zip*

Items and information to be released are;

- Treatment records
- Testing results
- Emergency-related information
- Reports of compliant and/or recommendations
- Screening tool information
- Ability to practice with reasonable skill and safety
- Records received from other sources pertaining to client
- Other:

*Specific record or records*

The purpose of this disclosure is:

\_\_\_\_\_  
\_\_\_\_\_  
The confidentiality of alcohol and drug use records maintained by Peer Assistance Services, Inc., is protected by Federal laws and regulations. Generally, we may not say to a person outside the program that a client involved with Peer Assistance Services, Inc., attends the program or disclose any information identifying a client --- unless;

1. You consent to the disclosure of information in writing.
2. The disclosure is ordered by a court; or as otherwise mandated by State and/or Federal Law.
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. If not sooner revoked, this consent shall expire two (2) years after my discharge from Peer Assistance Services, Inc. (42 C.F.R. § 2.31)

A copy of this document will have the same force and effect as the original.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date