Life Navigation, LLC
14 Ann Street
West Haven, CT 06516
jenniferbrothers@comcast.net
(203) 910-1111(phone) (203) 717-0210(fax)

CONSENT TO RELEASE/RECEIVE CONFIDENTIAL INFORMATION

I, _____, authorize **Jennifer Brothers** at the above address to communicate with the following person(s) regarding my treatment:

_____

_____

_____

This information is for the following purposes (any other use is prohibited):

_____

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken in reliance on it. This consent will last while I am being treated for substance dependence by the physician specified above unless I withdraw my consent during treatment. This consent expires 365 days after I complete my treatment, unless the physician above is otherwise notified by me.

I understand that the records to be released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

_____	_____	
Patient Signature	Date	
_____	_____	_____
Parent/Guardian Signature	Parent/Guardian (Print)	Date
_____	_____	_____
Witness Signature	Witness (Print)	Date`