AUTHORIZATION FOR RELEASE OF INFORMATION

*Items marked with an asterisk must be completed

Section I *Patient Information*	**First Name*:** _____ **MI*:**_____ **Last Name*:**_____ **Address:** _____ **Date of Birth*:** _____ **City:** _____ **State:** _____ **Zip Code:** _____ **Last 4 Digits of SSN:** _____
Section II *Authorized to Disclose*	**I hereby authorize disclosure of health information about the above-named individual as follows:** **Disclosing Entity or Person*:** _____ **Address:** _____ **Phone #:** _____ **Fax #:** _____ **City:** _____ **State:** _____ **Zip Code:** _____
Recipient(s)	**Receiving Entity or Person*:** _____ **Address:** _____ **Phone #:** _____ **Fax #:** _____ **City:** _____ **State:** _____ **Zip Code:** _____
Section III *Purpose of Disclosure*	**Purpose of Disclosure*:** ☐ to coordinate treatment ☐ to provide information ☐ at my request ☐ for treatment, payment, and/or health care operations ☐ other purpose (specify): _____ **Description of Information to be Disclosed*** _____ Specify time period, if desired: Release information only from the period _____ (mm/dd/yyyy) to (mm/dd/yyyy)
Section IV *Authorization*	**This authorization will remain in effect until revoked or shall expire on date or event specified below.** I understand that I may revoke or cancel this authorization at any time by submitting written revocation in the manner specified by the disclosing person/entity, except to the extent that action has been taken on it or if it is related to my participation in a treatment program as part of criminal justice-related proceedings. If this authorization has not been revoked, it will expire on the date or completion of the event stated below. If the recipient is a covered entity or business associate to whom a record (or information contained in a record) is disclosed for purposes of treatment, payment, or health care operations, the patient's record (or information contained in the record) may be redisclosed in accordance with the permissions contained in HIPAA regulations, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against the patient. For other recipients, there is the potential for the records used or disclosed pursuant to this consent to be subject to redisclosure by the recipient and no longer protected. **Expiration Date or Event*:** _____ I understand that I may refuse to sign this authorization if it is for purposes other than substance use disorder assessment, treatment or payment for that treatment. My refusal to sign it for other purposes will not affect my ability to obtain treatment, my enrollment in or eligibility for benefits, or payment provided for those services, unless conditioning of my authorization is expressly permitted under federal law. _____ _____ **Signature of Individual** **Date (mm/dd/yyyy)** _____ _____ **Signature of Personal Representative (if applicable)** **Date (mm/dd/yyyy)** Relationship of Personal Representative – if applicable *(Personal representative shall submit proof of authority to the disclosing entity)*: ☐ Parent ☐ Legal Guardian ☐ Healthcare POA ☐ Executor/Administrator ☐ Other
Administrative Use Only	Method of Delivery (e.g. paper, fax, electronic): _____ Date Released: _____

NOTICE TO RECIPIENTS OF SUBSTANCE USE DISORDER INFORMATION:

ODM 10221 (10/2025) 42 CFR Part 2 prohibits unauthorized disclosure of these records.