

**CONSENT FOR RELEASE OF INFORMATION  
CONCERNING  
ALCOHOLISM/DRUG ABUSE PATIENT**

PATIENT'S LAST NAME	FIRST	M.I.
CASE NO.		
FACILITY		UNIT

**INSTRUCTIONS:** **GIVE A COPY OF THE FORM TO THE PATIENT!** Prepare one (1) copy for the Patient's Case Record. If this form is used for billing purposes, prepare an additional copy for the Resource and Reimbursement Agent. If this form is sent to another agency with a request for information, prepare an additional copy for the Patient's Case Record.

**[DISCLOSURE]/ [RELEASE] WITH PATIENT'S CONSENT**

EXTENT OR NATURE OF INFORMATION TO BE DISCLOSED/RELEASED Presence, status, psychosocial history, diagnosis, treatment plans, recommendations, discharge summary, medical records, toxicology screens, labs, and address. Other _____	
PURPOSE OR NEED FOR DISCLOSURE/RELEASE  TO COORDINATE TREATMENT EFFORTS WITH PATIENT'S: _____ (GENERAL CATEGORY)	
NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING/RELEASING INFORMATION  Between: Brooks - TLC Hospital System, Inc. Inpatient CD 845 Main Road – Routes 5&20 Irving, NY 14081	NAME OR TITLE OF PERSON OR ORGANIZATION TO WHICH THE DISCLOSURE/RELEASE IS TO BE MADE  And: (Type in Name/ Address/ Phone Number)

I, the undersigned, have read the above and authorize the staff of the disclosing/releasing facility named to disclose/release such information as herein contained. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure/release is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Pts. 160 & 164; and that redisclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part.

Time period, event or condition replacing period specified above: One (1) Year from date of discharge

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**NOTE:** Any information released through this form will be accompanied by the form prohibition on Re-disclosure of Information Concerning Alcoholism/Drug Abuse Patient (TRS-1)

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

_____	_____
(Signature of Patient)	(Signature of Parent/Guardian, when required)
_____	_____
(Print Name of Patient)	(Print Name of Parent/Guardian)
_____	_____
(Date)	(Date)