**Release of Information to Third Parties**

Patient Name:

Address:

Date of Birth:

SS#:

Telephone number:

Email address:

I hereby give my permission for Donlan Counseling Services to exchange information regarding my treatment with the person or agency identified below.

Person or Agency name:

Address:

Telephone number:

Email address:

Relationship:

Please identify the information you want to be shared (check or highlight):

Admission/Intake notes

Diagnosis

Progress notes

Treatment Plan

Presence in Counseling

I understand that information disclosed in this request about substance abuse treatment is disclosed from records protected by Federal Confidentiality rules (42 CFR Part 2). Federal rules prohibit further disclosure of this information unless such disclosure is permitted by the written consent of the person to whom it pertains or as otherwise permitted by (42 CFR Part 2). A general authorization for the release of information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. I also understand that I may withdraw this permission at any time by submitting written notification of such revocation. Otherwise, this permission will expire six months following the termination of treatment in any Gosnold programs.

I have read and understand the above statements and do hereby voluntarily consent to the disclosure of the information and/or medical records (including alcohol/drug abuse records) to those persons/agencies named above. I hereby release Gosnold and its employees or representatives from any liability arising from the release of this information, provided said release of information is done substantially in accordance with applicable law.

Patient signature and date:

DCS Staff Signature and date: