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**Consent for the Release of Information**

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| Client Name: |  |
| Date of Birth: |  |
| I hereby authorize and request Adult & Teen Challenge of the Smokies Men’s Center to obtain/release any information regarding my medical, psychological, legal, or financial situation from/to any entity which has participated in my care or legal issues. |
| I understand that such disclosure will be made for the following purposes: medical, psychological, legal and financial.1. I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without consent unless otherwise provided for in the regulations.
2. I also understand that I may revoke this consent at any time except that action has been taken in reliance on it. If not earlier revoked, this consent expires 30 days after discharge from the program.
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| Signature of Client: |  |
| Date: |  |