SUBSTANCE ABUSE REHABILITATION PROGRAM

SIGNIFICANT OTHER CONTACT AUTHORIZATION

I_____ authorize SARP, _____ to make personal contact with _____ to ascertain my substance abuse history in order to assist in determining my need for substance abuse treatment, and for the development of my individual rehabilitation/treatment plan if required. I understand that the purpose of this contact is to assist the drug and alcohol counselors at SARP, _____ to better understand my situation, and to more accurately identify and address potential problems with alcohol or other drugs. I also understand that any information regarding my substance abuse history is to be used strictly to determine my need for substance abuse treatment and to aid in the development of my treatment plan.

_____	_____	_____
PATIENT'S NAME (PRINTED)	PATIENT'S SIGNATURE	DATE

_____

PATIENT'S SSN

_____	_____	_____
COUNSELOR'S NAME (PRINTED)	COUNSELOR'S SIGNATURE	DATE
_____	_____	_____
COUNSELOR'S NAME (PRINTED)	COUNSELOR'S SIGNATURE	DATE

Patient Name		Rank/Grade	Sex
SSN/Identification Number	Status	Date of Birth	
Branch of Service	Organization		
Sponsor's Name	Relationship to Sponsor		