SUBSTANCE ABUSE REHABILITATION PROGRAM
CONSENT TO OBTAIN INFORMATION

The purpose or need for this information is to assist the staff in my rehabilitation efforts. I understand I may revoke this consent to obtain information at any time and that upon fulfillment of the stated purpose(s); this consent will automatically expire without my expressed revocation. Unless sooner revoked or fulfilled, this consent will expire 1 year from the date signed. Information provided by other professionals will be held strictly confidential and will not be released without my expressed written consent. I realize this communication will reveal my presence in treatment to the person contacted.

Communication between _____ and _____
Internal Program Person, Agency/Designated

ADDRESS
_____

_____
City, State and Zip Code

Attention: _____

ADDRESS
_____

_____
City, State and Zip Code

Attention: _____

As specified and agreed to below:

OBTAIN INFORMATION for the following purpose(s):

_____

_____

Information to be obtained related to my:
_____ Chemical usage _____ Medical history _____ Social history/background
_____ Education _____ Other
Specify: _____

Methods for obtaining authorized information are:
_____ Concerned person questionnaire _____ Written _____ Telephone _____ Other
Specify: _____

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____

NOTE: This information being requested from you is protected under confidentiality requirement by Federal Law. Federal regulations prohibit disclosure of this information without the expressed written consent of the patient to whom it pertains, or as otherwise permitted by such regulations. A general medical authorization for the release of medical or other information is not sufficient for this purpose.

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