

**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 _____	ADDRESS _____
_____	_____
City, State and Zip Code _____	City, State and Zip Code _____
Attention: _____	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	