

**DEAF ADDICTION SERVICES AT MARYLAND
University of Maryland School of Medicine**

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I, _____ authorize my DASAM Counselor
(Name of Client)

[] to obtain from: _____
(Name of Person or Organization) (Phone Number)

[] to disclose to: _____
(Name of Person or Organization) (Phone Number)

PURPOSE OF DISCLOSURE: _____

NATURE OF INFORMATION: _____

EXPIRATION DATE (Consent expires in one year unless revoked in writing prior to the date below).

1. EXACT DATE _____
2. CONDITION: N/A _____
3. EVENT: N/A _____

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g., as a condition of Parole and Probation, the Courts, etc.). This revocation must be submitted in writing to DASAM staff.

SIGNED _____ **DATE** _____
(CLIENT)

SIGNED _____ **DATE** _____
(COUNSELOR)

“This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you making any further disclosure of this information unless further disclosure is expressly 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 medical or other 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.”