Consent to Release / Receive Confidential Information

I, (*Name:*)____, (*Date of Birth:*) ________________,authorize Andrews Institute for Addiction Treatment at 4402 Peach St., Suite 4, Erie, Pennsylvania 16509 to:

☐ **Receive** my medical history information **from** the following physician(s)/healthcare professional(s):

(Name/address:) ____

(Name/address:) ____

☐ **Release** my treatment information/records **to** the following physician(s)/healthcare professional(s):

(Name/address:) ____

(Name/address:) ____

☐ **Release** my treatment information **to** the health insurance company listed below for billing purposes:

Insurance provider (name/address): ____

This information is for the following purposes (any other use is prohibited): ____________________________________

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I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken in reliance on it. This consent will last while I am being treated by Andrews Institute for Addiction Treatment unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless Andrews Institute for Addiction Treatment is otherwise notified by me.

I understand that the records to be released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related illnesses. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

I acknowledge that I have been notified of my right pertaining to the confidentiality of any treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand these rights.

______________________________		______________________
Patient Signature		Date
Parent/Guardian Signature	Parent/Guardian Name (Printed)	Date
Witness (Signature)	Witness Name (Printed)	Date