ADDICTION CONNECTIONS RESOURCE, INC.

1804 HARFORD ROAD, FALLSTON, MD 20147

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AUTHORIZATION FOR RELEASE OF INFORMATION

I, ____, hereby authorize Addiction Connections Resource, Inc. (ACR) and its staff to **RELEASE or OBTAIN** information **TO or FROM**:

____

(name of Treatment Facility or Halfway House)

The following identifying information from my records: Verbal or written communication to/from the above-named Facility.

The purpose or need for such disclosure is: A documentation requirement for ACR grant dollars used, and to provide continuity of care.

This authorization will expire one (1) year from the date of signature. I also understand that this authorization may be revoked by me, in writing, at anytime except to the extent that action has already been taken.

____ _________________________

CLIENT SIGNATURE **DATE SIGNED**

I understand that my records are protected under Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for by the Regulations.

PROHIBITION OF REDISCLOSURE

This information has been disclosed to you from records protected by Federal Confidentiality Regulations (42 CFR Part 2). The Federal Regulations 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 Regulations restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.