Community Action Organization of Western New York, Inc.
Drug Abuse, Research and Treatment Clinic
1237 Main Street
Buffalo, New York 14209
(716) 884-9101
Fax (716) 884-7703

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____ D.O.B. _____ hereby consent to communication
(NAME OF PATIENT)

between Drug Abuse, Research and Treatment (DART) and

_____
(NAME OF PERSON OR ORGANIZATION TO WHICH DISCLOSURE IS TO BE MADE)

the following information: _____
(NATURE & AMOUNT OF INFORMATION TO BE DISCLOSED)

_____

_____

_____

The purpose of the disclosure authorized in this consent is to:

_____
(PURPOSE OF DISCLOSURE, AS SPECIFIC AS POSSIBLE)

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42, C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 &164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

_____
(SPECIFICATION OF THE DATE, EVENT, OR CONDITION UPON WHICH THIS CONSENT EXPIRES)
This consent shall expire in twelve (12) months from the date signed unless otherwise indicated

I understand that generally DART may not condition my treatment on whether or not I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

Dated: _____

_____
Signature of patient