

# Jim Cosenza, LCSW, CADC

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## Substance Abuse Treatment Release Authorization

Date: \_\_\_\_\_

I, \_\_\_\_\_  
Patient First Name Patient Middle Initial Patient Last Name

residing at \_\_\_\_\_  
Street Address Apartment or Unit Number City State Zip

Date of Birth: \_\_\_\_\_ and Telephone Number: \_\_\_\_\_

hereby authorize and request **Jim Cosenza, LCSW, CADC and staff** to obtain and disclose written, oral, or electronic information with:

**Person, Agency, or Facility:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_ **FAX:** \_\_\_\_\_

the following information: (please initial in boxes)

<input type="checkbox"/> initials	Assessment	<input type="checkbox"/> initials	Participation in Treatment
<input type="checkbox"/> initials	Diagnosis	<input type="checkbox"/> initials	Medical Information
<input type="checkbox"/> initials	Psychosocial Evaluation	<input type="checkbox"/> initials	Toxicology Reports
<input type="checkbox"/> initials	Psychological Evaluation	<input type="checkbox"/> initials	Educational Information
<input type="checkbox"/> initials	Psychiatric Evaluation	<input type="checkbox"/> initials	Discharge/Transfer Summary
<input type="checkbox"/> initials	Treatment Plan/Summary	<input type="checkbox"/> initials	Continuing Care Plan
<input type="checkbox"/> initials	Current Treatment Update	<input type="checkbox"/> initials	Treatment Progress
<input type="checkbox"/> initials	Medication Management	<input type="checkbox"/> initials	Demographic Information
<input type="checkbox"/> initials	Other: _____		

**Purpose:** The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

**Revocation:** I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to [Insert Name] at [Insert Contact Information]. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

**Expiration:** Unless sooner revoked, this authorization expires on the following date:

\_\_\_\_\_

**Conditions:** I further understand that Jim Cosenza, LCSW, CADC will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:

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**Form of Disclosure:** Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

**Redisclosure:** Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. I will be given a copy of this authorization for my records.

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**Signature of Patient or Legally Authorized Patient Representative**

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**Date**

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**Relationship to Patient**

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**Jim Cosenza, LCSW, CADC**

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**Date**