



PERINATAL TREATMENT SERVICES

**AUTHORIZATION TO RELEASE AND EXCHANGE CONFIDENTIAL INFORMATION**

I, \_\_\_\_\_ hereby authorize Perinatal Treatment Services (PTS) to receive and disclose written and/or verbal information pertaining to the following: (patient to initial )

- \_\_\_\_\_ My identity and identifying information
- \_\_\_\_\_ The fact that I am a patient of their clinic
- \_\_\_\_\_ Social, psychological or drug history or evaluation
- \_\_\_\_\_ Medical exams, evaluations or medication prescribed
- \_\_\_\_\_ Urinalysis records
- \_\_\_\_\_ Progress or lack of progress during my treatment
- \_\_\_\_\_ Other (specify) \_\_\_\_\_

This information checked above should be released to/received by:

\_\_\_\_\_  
(Individual and/or Agency)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Contact Person)

\_\_\_\_\_  
(Telephone Number)

The information is needed for (patient to initial):

- |   |                                      |
|---|--------------------------------------|
| _____ Treatment   | _____ Employment                     |
| _____ Probation or parole monitoring                    | _____ Preparation of a legal defense |
| _____ Determining eligibility for benefits or treatment | _____ CPS written agreement          |
| _____ Other (specify) _____                             |                                      |

“I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also 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., probation, parole, etc.) and that in any event this consent expires automatically as described below:”

Except for court ordered treatment this consent will expire 90 days from the time the release is signed or upon the expiration date stated below. The expiration date must last no longer than reasonably necessary to serve the purpose for which it is given.

Patient Signature: \_\_\_\_\_  
(13 years and older)

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

Witness: \_\_\_\_\_

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

Continuation Updates:

- |                           |                        |                           |
|---------------------------|------------------------|---------------------------|
| Authorization Date: _____ | Expiration Date: _____ | Patient's Initials: _____ |
| Authorization Date: _____ | Expiration Date: _____ | Patient's Initials: _____ |
| Authorization Date: _____ | Expiration Date: _____ | Patient's Initials: _____ |
| Authorization Date: _____ | Expiration Date: _____ | Patient's Initials: _____ |