Arizona Behavioral Counseling & Education, Inc.

Authorization for Release of Information

I, _____, authorize Arizona Behavioral Counseling (ABC) to communicate and exchange information about me which includes my name, address, phone number, reason for referral, attendance, screening results, intake, program participation, progress report and compliance status, incident reports and health emergencies with the person and/or entity below:

Agency and/or Person Name: _____

Address: _____

Phone Number: _____

Fax Number: _____

I understand that my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, chapter 1, Part 2, volume 40, number 127 and cannot be disclosed without my written consent, unless otherwise provided for in the regulations. I may revoke this consent at any time. This authorization expires automatically seven (7) years from today's date.

Client's Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

Client Signature: _____

Today's Date: _____