Arizona Behavioral Counseling

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Arizona Behavioral Counseling to exchange information about my name, address, phone number, reason for referral, screening results, program participation, progress report and compliance status with the entity below:

_____

Agency or Name

_____

Mailing Address

_____

City State Zip Code

_____ _____

Daytime Telephone 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, 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 with reliance on it. Otherwise, this consent expires automatically one year from today's date.

_____ _____

Client Name (Print Legibly) Date of Birth

_____ _____

Client Signature Today's Date

_____

Mailing Address City State Zip code

_____ _____

Daytime Telephone Number Cell Phone

P.O. BOX 36158 PHOENIX, ARIZONA 85067-6158 PHONE 602-788-1116 FAX 602-788-1119