

**Consent for the release of confidential alcohol or drug treatment and
hiv/aids information to comply with disease reporting requirements**

Adapted from the Substance Abuse and Mental Health Services Administration (TAPS 13)

I, _____, authorize

(Name of Resident)

(Name or general designation of program making disclosure)

to disclose to _____

(Name of person or organization to which disclosure is to be made)

the following information:

*(1) information that State law requires to be reported about my diagnosis and treatment for --
[initial any which apply]*

_____ HIV infection _____ AIDS

*(2) my name and other personal identifying information, if required to be reported by State law; and
(3) information about my status as a patient in alcohol or drug treatment, if required to be reported by State law.*

The purpose of the disclosure authorized herein is to: _____

(Purpose of disclosure as specific as possible)

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 HIV-related information about me, STD- related information about me, and TB- related information about me is protected by State law and cannot be disclosed unless the disclosure is authorized by State law. 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, and that in any event this consent expires automatically as follows:

(Specification of the date, event, or condition upon which this consent expires)

Dated: _____

Signature of resident: _____

I refuse to sign this document.

Signature of Resident (Parent/Guardian if client is minor)

Date

