S.A.R.P.H.
CRI1A.PRO

Consent for Release of Information

I, ____,
(Name and Social Security Number of Participant)
give my consent to ____
(Name/Address/Telephone number of facility/provider)
____

to disclose to **S.A.R.P.H.** the following medical and/or psychiatric information, which may include drug and alcohol abuse/addiction treatment information and/or HIV-related information from the medical records pertaining to my treatment or hospitalization on or about __________________________, for the sole purpose of maintaining my participation in the **S.A.R.P.H.** program in good standing through monitoring of my treatment and recovery process.

I understand that the information disclosed will be used solely for the purpose of verifying and monitoring treatment and recovery, in order to determine my eligibility for continued participation in the **S.A.R.P.H.** program. The information will be limited to:

> Admission Summary; Psychosocial history/evaluation; discharge summary; aftercare plan; progress notes; attendance records; results of urine/blood screens; therapist assessment of motivation/commitment to treatment/recovery; prognoses; other patient records or reports as required to establish appropriateness of diagnosis and treatment and treatment progress.

I understand that I have no obligations whatsoever to disclose information from my patient record and that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon, by notifying **S.A.R.P.H.** in writing; and/or specifying a date, event or condition upon which my consent will expire without revocation, which I have done below.

This consent shall automatically expire upon the termination of the
S.A.R.P.H. monitoring agreement/contract.
(Date, Time, Event or Condition)

______________________________ **X** ____________________________________
(Date signed) Participant's Signature

______________________________ **X** ____________________________________
(Date signed) Witness