

CONSENT TO RELEASE and /or RECEIVE CONFIDENTIAL INFORMATION

this consent at any time except to the extent that action has already been taken. I understand that I am entitled to a copy of this document in completed form certify that this document has been explained to me and that I understand its contents and have checked either "yes" or "no in each of the boxes.	I,		(= 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,									
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Diagnosis Discharge Information Discharge Inform			Lab Results		☐ Medicati	edications				Substance Abuse		
Specify any limitations on release such as dates of service/treatment:			Assessment		☐ Status/A	ttendance				HIV		
Specify any limitations on release such as dates of service/treatment: Federal and Delaware State law provide special protections for the release of substance abuse, HIV or other health related information. (Ref: 42 CFR, 45 CFR, DE Title 16) This information will be used ONLY for the following reasons: (Please check either Yes or No—do not leave both boxes blank) Yes No To coordinate treatment with my primary care physician and/or my managed care organization (insurance company) Plan for & provide referral, assessment, ongoing treatment or services, and/or medical care To obtain insurance, employment, social services or government benefits To enable judges, attorneys, and/or probation/parole officers to support treatment or services, or make legal decisions on my behalf To coordinate treatment or services with my family/concerned persons To coordinate treatment or services with my school, employer and/or EAP representative Other: (Specify) I understand that by law, I do not need to consent to this release of information. I do so willingly and voluntarily for the purpose(s) specified above. I can withdra this consent at any time except to the extent that action has already been taken. I understand that I am entitled to a copy of this document in completed form certify that this document has been explained to me and that I understand that I am entitled to a copy of this document in completed form certify that this document has been explained to me and that I understand that on the extent that a consent expires on: In coordinate treatment or services with my school, employer and/or EAP representative Other: (Specify) Linderstand that by law, I do not need to consent to this release of information. I do so willingly and voluntarily for the purpose(s) specified above. I can withdra this consent at any time except to the extent that action has already been taken. I understand that I am entitled to a copy of this document in completed form certify that this document has been explained to me and that I u			Diagnosis		☐ Discharç	ge Information						
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