AUTHORIZING Patient's NAME (please print): Last: _____ First _____ M.I.____

Date of Birth: _____ Social Security #: _____ - _____ - _____

**AUTHORIZATION FOR RELEASE OF INFORMATION AND DISCUSSION BETWEEN**

**National Alliance of Methadone Advocates (NAMA)**

435 Second Avenue
New York, NY 10010
tel/fax: 212 595-6262

**AND**

_____ (Person/Facility)

_____ (Address)

_____ (Address)

_____ (City, ST, Zip)

(telephone) _____ (fax)_____

WE REQUEST ALL PERTINENT MEDICAL RECORDS FROM ATTENDING PHYSICIANS, HOSPITALS AND OTHER HEALTH CARE PROVIDERS. THE PURPOSE OF THIS RELEASE IS TO ALLOW WRITTEN AND/OR VERBAL COMMUNICATION PERTAINING TO MEDICAL INFORMATION INCLUDING BUT, NOT LIMITED TO: clinical and discharge summaries, other complaints, counselors notes, medical orders, the results of medical and psychiatric evaluations, case reports and psychological assessments. THIS RELEASE ALSO AUTHORIZES COMMUNICATIONS in verbal or written form between NAMA and its representatives _____ and the above named person facility or facility representatives pursuant to the patient listed above. This authorization may be withdrawn in writing at any time and terminates on _____.**

**ADDITIONAL INFORMATION REQUIRED:** _____

_____

_____

I understand that information specific to my medical history can be released with this consent. I can cancel this consent at any time but I understand the cancellation will not affect any information previously released under the agreement. I further understand that my notice of cancellation must be in writing.

I understand that information about my case is confidential and protected under the Federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42CFR, Part 2 and 45 CFR, Parts 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I approve the release of this information. I understand what this agreement means and I am satisfied with my explanations which I may have requested and received.

| | |
|---|---|
| _____ | _____ |
| Signature of Patient | Signature of Witness |
| _____ | _____ |
| Printed name | Printed name |
| _____ | _____ |
| Date of Signature | Date of Signature |

** *According to HIPPA the new patient privacy regulations a release must have a specific start time and end time which should not be more than one (1) year for compliancy.*