Triad EduPsych, P.C.

316 Alexander St., Suite 6
Marietta, GA. 30060

1708 Peachtree Street, Suite 530
Atlanta, GA 30309

770 331-8760 Fax: 678 581-0146
www.triadedupsych.com

Psychotherapy, Employee Assistance, Educational Consulting, Disability Services & Advocacy

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I _____, authorize_____ (Name & Title of Person/Designation of Program) To disclose to:

_____

(Name/Title of Person or Organization)
The following information:_____
_____
_____
_____
_____
_____
_____
_____

The purpose of the disclosure authorized by this Release 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, 42CFR 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 in reliance on it, and that, in any event this consent expires automatically as follows (Specific date, event, or condition upon which this consent expires)
_____
_____
_____
_____
_____
_____ _____

_____ _____
(Signature of Patient or Guardian) (Date)