Medical Release of Information

I, _____ authorize the Embrasse Resources treatment team and my buprenorphine doctor to **disclose** the following section(s) from my medical record held at Embrasse Resources including: □ pertinent medical history, □ physical examination, □ medications, □ diagnostic tests, □ therapy records, or □ entire medical record to the following:

1. Pharmacy:_____
2. Physician(s): _____
3. Medical Group: _____
4. Other Agency: _____
5. Significant Other: _____
6. Next of Kin: _____

I understand that my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, Code of Federal Regulations , Title 42, Part 2, and cannot be disclosed without any written consent unless otherwise provided for in the regulations.

I also understand that this consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate in one calendar year from the date signed below or sooner, if I provide written instruction to terminate the medical release of information.

Printed Name Patient Signature Date