**APS Healthcare, Inc.**
**Consent to Release Information to Primary Care Physician (PCP)**

I, _____, residing at:

_____

Address City State Zip

Hereby give my informed consent for _____ to
Name of Provider

(*Please circle)*
1. Talk with and/or
2. release written documentation

regarding my treatment to _____.
Name of PCP

I understand that my records are protected under Federal Regulation 42 CFR, Confidentiality of Alcohol and Drug Abuse and under the general laws of my state and cannot be redisclosed without written consent, except as specifically stated by law.

I understand that, under Federal law, the above named provider may release information from my record without my consent when:

1. there is indication of child abuse or abuse of disabled adults;
2. given best clinical judgement, there is indication of dangerousness to self or others (suicidal or homicidal); or
3. required to present records to comply with a court order.

I understand that Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate state or local authorities.

This authorization expires ninety (90) days from today's date. I understand that I may revoke my authorization to release information at any time in writing and such revocation will be effective on the date of receipt of my revocation. In the event action already has been taken prior to said receipt of revocation, such prior actions are covered by the pre-existing release.

_____ _____/_____/_____
Signature of Member Date

_____ _____/_____/_____
Signature of Witness Date