Camelot of Staten Island, Inc.

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, ______________________________ **authorize Camelot Counseling Centers to:**
(Name of Client)

Disclose to: ______________________________

Following information: Acknowledge my presence in treatment / self-disclosure

Date:

The purpose of the disclosure authorized in this consent is to:

Participation in ______________________________

(Purpose of disclosure, as specific as possible)

I understand that the above information is protected by Federal a Regulation 42 CFR, Part 2, "Confidentiality of Alcohol and Drug Abuse Patient Records" and cannot be disclosed without my written consent unless otherwise provided for the regulations. I choose to do so willingly and voluntarily for the purposes mentioned above. The duration of this authorization is one year unless I specify otherwise, event or condition up which it will expire sooner. I understand that I may revoke this consent at any time by notifying my counselor in writing except to the extent that action has been taken in reliance on my consent.

ONE YEAR AFTER DATE OF LEGAL OBLIGATIONS OR DATE OF ADMISSION
(Specification of the date, event, or condition upon which this consent expires)

I understand that generally Camelot of Staten Island, Inc. may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances, I may be denied treatment if I do not sign a consent form.

Date: ______________________________

____
Signature Of Client

____
Signature Of Parent, guardian or authorized representative (When Required)

XXX-XX-
____
Social Security Number
Last 4 digits if client is under 18

/ /
____
Date Of Birth

C:\Users\antho\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\Z8ND56ML\Blank Consent 2020.docx