

DISCLOSURE OF MEDICAL RECORDS - DRUG AND ALCOHOL

1. I, _____ Request: _____ Authorize: _____

2. (name or general designation of program which is to make the disclosure) _____

3. To disclose: (kind and amount of information to be disclosed) _____

4. To: (name or title of the person or organization to which disclosure is to be made) _____

5. For: (purpose of the disclosure) _____

6. Date: (on which this consent is signed) _____

7. Signature of patient _____

8. Signature of parent or guardian (where required) _____

9. Signature of person authorized to sign in lieu of the patient (where required)

10. 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 upon: production of the medical records requested herein, or on:

OMA-RDAR-99