CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____, authorize

(NAME OF PATIENT) (DATE OF BIRTH)

_____ **(WHERE ARE WE GETTING YOUR RECORDS FROM)**

(NAME OR GENERAL DESIGNATION OF PROGRAM MAKING DISCLOSURE)

to disclose to:

Novo Healthcare, 223 Madison St, Ste 103, Madison, TN 37115 Phone: (615) 860-0808 Fax: (615) 860-0809

(NAME OF PERSON OR ORGANIZATION TO WHICH DISCLOSURE IS TO BE MADE)

the following information:

_____

(NATURE OF THE INFORMATION, AS LIMITED AS POSSIBLE)

The purpose of the disclosure authorized herein 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, 42 CFR 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:

One Year from the date of signature unless written or oral revocation from patient

(SPECIFICATION OF THE DATE, EVENT, OR CONDITION UPON WHICH THIS CONSENT EXPIRES)

_____

(Date) (Print Name) (Signature of Participant)

_____

(Date) (Print Name) (Signature of Parent, Guardian or Authorized Rep. when required)

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patients.