SADDLEBACK MEDICAL GROUP

23961 CALLE DELA MAGDALENA SUITE 130/232/400/500 LAGUNA HILLS, CA 92653 * FAX (949) 837-0641

CONSENT FOR RELEASE OF ALCOHOL OR DRUG ABUSE PATIENT HEALTH INFORMATION OR RECORDS

I hereby authorize _____

(Facility Name and Physician Name)

to disclose records obtained in the course of the diagnosis and treatment of _____

(Name of Patient)

for alcohol and / or drug abuse to

_____

(Name of Person or Facility to which Disclosure is Made)

_____

(Address, State, and Zip Code of Person or Facility)

The disclosure of records authorized herein is required for the following purpose:

_____

_____

_____

and such disclosure shall be limited to the following specific types of information:

_____

_____

_____

This consent is subject to revocation by the undersigned at anytime except to the extent that action has been taken in reliance hereon, and if not earlier revoked, it shall terminate on:_____

_____ without express revocation.

(Date, Event, or condition)

_____

Dated

_____

(Patient, Parent, Guardian, or Authorized Representative of the patient)

_____

(If signed by other than patient, indicate relationship)