BP-A0528 **TRANSITIONAL DRUG ABUSE TREATMENT**
JUN 10 **AUTHORIZATION FOR RELEASE OF INFORMATION** CDFRM
U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

Inmate Name	Register Number	Date
Date of birth	CCC	Judicial District

I authorize the Federal Bureau of Prisons to :

☐ **Release Information To:**

Name/Facility: _____

Address: _____

☐ **Obtain Information From:**

Name/Facility: _____

Address: _____

This is to include:

☐ **Treatment Summary and Referral Form**
☐ **Substance Abuse Assessment**
☐ **Mental Health Assessment**
☐ **Treatment Plans**
☐ **Monthly Progress Report**
☐ **Discharge Summary**
☐ **Sign In/Out Sheets**
☐ **Other (Describe)** _____

The purpose of the disclosure is to inform the person(s) listed above of my attendance, progress and continuation of substance abuse or mental health treatment .

I understand this authorization is voluntary and that I may refuse to sign this authorization.

I understand that my alcohol and/or drug tre atment records may be protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 & 164. 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.

I understand that this authorization will expi re on _____. I understand that I may revoke this authorization at any time by sending a written request to the Transitional Drug Abuse Coordinator at _____.

I have read the above or I have had it read to me and I authorize the disclosure of Protected Health Information as stated.

Signature of Patient (Fax Signature Valid Original)	Date (Month, Day, Year)	Staff Witness

cc: Transitional Drug Abuse Treatment Office