

**CONSENT FOR THE RELEASE OF
CONFIDENTIAL ALCOHOL AND DRUG TREATMENT INFORMATION
by Substance Abuse Assessment and Treatment Providers to Departments of Social Services**

Head of Household _____ **DSS Office** _____

MA# _____ **AU ID#** _____ **SS#** _____

I, _____, authorize the substance abuse assessment or
Print name

treatment provider that I am referred to for assessment or treatment, or that is treating me, to report to the Department of Social Services (DSS) office named above the information listed below, if it has this information about me:

- That the substance abuse treatment provider has received my consent form and referral for treatment from the Addictions Specialist;
- That I did not keep an appointment for a comprehensive substance abuse assessment ordered by the Addictions Specialist in the DSS office;
- That a comprehensive substance abuse assessment indicates that I am not in need of substance abuse treatment;
- That I have been referred for substance abuse treatment;
- That I did not schedule and appear for my first appointment for substance abuse treatment within 30 days of referral or as soon as I could get an appointment;
- That I am waiting for room for me in the kind of substance abuse treatment program I was referred to;
- That I am enrolled in a substance abuse treatment program;
- That I am not maintaining active attendance or participation in the treatment program;
- That I have been discharged from a treatment program for noncompliance;
- That I successfully completed the substance abuse treatment that I was referred to;
- That I was referred to another substance abuse treatment program, and the name of that program.
- That I have been tested for drug use and results of the test. **(FOR PERSONS CONVICTED OF A DRUG FELONY)**

This release is necessary to comply with State law which requires that this information has to be reported to your local DSS office if you are going to receive Temporary Cash Assistance (TCA) benefits, and to receive TCA and Food Stamps if you have been convicted of a drug felony.

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 reported to anyone without my written consent unless those regulations provide otherwise. I also understand that I can cancel this consent at any time, but the cancellation will not apply to the past acts someone who was covered by this consent at the time and relied on it; if I do cancel this consent, I could lose my TCA or Food Stamp benefits. In any case, this consent will automatically be canceled when my TCA and Food Stamp benefits end.

Signature

Date

PROHIBITION OF REDISCLOSURE

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The federal rules prohibit any further disclosure of this information unless 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 treatment patient.