MedPro Treatment Centers

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION FOR GUEST-DOSING

I, _____

SS#: _____ D.O.B:_____ A.K.A:_____

authorize, _____**MedPro Treatment Centers**_____

(Name or general designation of program making the disclosure)

to disclose written and oral communication to_____

(Name of person or organization to which disclosure is made)

The following guest-dosing information:

- Full Name
- Social Security Number
- Date of Birth
- Driver's License or State ID Number
- Identifying Information
- Dose Level/Medical Status
- Phase Level (number of take-home permitted)
- Other _____

  _____

The purpose of the disclosure authorized herein is to:

- Facilitate guest-dosing arrangements

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:

_____

(Date, event, or condition upon which this consent expires)

Patient signature:_____Counselor_____Date:_____