



CONSENT FOR RELEASE OF INFORMATION

I _____ (Print Name of or Parent/Guardian) give consent for DABQ, LLC to exchange any and all information (including that relating to substance abuse and medical conditions) pertaining to my treatment, to the extent such disclosure is necessary for coordination of treatment, case management, claims processing, quality assurance, or utilization review purposes.

I understand that:

- I can revoke my consent at any time by submitting a written request to that effect, except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent.
- I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.
- Release of HIV related information requires additional information.
- This authorization expires _____ (insert applicable date or event) or if no date is indicated, 12 months from the date of signing this form.

With the following specific exception of information and/or persons:

I authorize DABQ, LLC to exchange information with:

Name and Relationship to Client	Telephone & Fax Numbers	Email	Date of consent	Initials

My signature below indicates that I have read and understand the stipulations above.

SIGNATURE: _____ Date: _____

PARENT OR GUARDIAN SIGNATURE: _____ Date: _____



DABQ, LLC Representative: _____ Date: _____