CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____, authorize
(Name of client)

Serenity Recovery Centers, Inc.

To disclose to _____

_____

_____
(name, address, phone, fax)

The following information:

_____

_____

The purpose of the disclosure authorized in this consent is to be:

_____

_____

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality 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. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing 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:

_____
(Specification of the date, event, or condition upon which this consent expires)

I understand that generally Serenity Recovery Centers, Inc. may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

Dated: _____

_____
(Client signature)

_____
(Signature of parent/guardian/representative)