

**Kansas Association of Addiction Professionals  
Ethics Committee  
225 SW 12<sup>th</sup> Street  
Topeka, KS 66612**

**Consent for the Release of Confidential Information**

I, \_\_\_\_\_, hereby authorize  
Name of Client/Patient (Please Print)

\_\_\_\_\_  
Name of Treatment Provider (Please Print)

To disclose to

The Ethics Committee of the Kansas Association of Addiction Professionals the following information:

**ALL RECORDS PERTAINING TO MY CARE PROVIDED BY THE  
ABOVE NAMED TREATMENT PROVIDER**

The **PURPOSE** of this disclosure is to facilitate the Ethics Committee's investigation of an alleged ethics violation involving the above named provider.

I understand that my alcohol and/or drug abuse 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 360 days from the date this release is signed.**

\_\_\_\_\_/\_\_\_\_\_  
Signature of Client / Date

\_\_\_\_\_/\_\_\_\_\_  
Signature of Parent/Guardian/Authorized Representative / Date