



Waiver for Release of Information from the Mental Health Provider

I, _____, hereby authorize the Coordinator of the Alternative Program for Chemical Dependency/Substance Use Disorders (Program) and/or designee to receive from:

such information as requested by the Coordinator or designee, related to my mental health status to allow the Coordinator to determine if I can be effectively treated for my chemical dependency and my eligibility for continued participation in the Program.

This waiver will terminate when I am no longer a Participant in the Program.

Participant Signature

Date

Effective April 2015