

CONSENT FOR THE RELEASE
OF CONFIDENTIAL INFORMATION

I, _____ authorize Maintenance and Recovery Services
(Name of Patient)

to disclose to _____ Patient Advocacy Group

the following information presence, financial information, any information
pertaining to request for financial help to pay for one week of methadone

The purpose or need for such disclosure is for financial assistance to pay for
methadone.

I understand that my records are protected under the Federal Confidentiality Regulations 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 (e.g. probation, parole, etc.) and that in any event this consent expires automatically as described below. I agree that this consent may be faxed or photocopied.

Specification of the date, event, or condition upon which this consent expires:

Executed this _____ day of _____, 2008

Signature of Patient

Signature of Witness