ASAP CLIENT'S CONSENT STATEMENT FOR RELEASE OF TREATMENT INFORMATION

For use of this form, see AR 600-85; the proponent agency is DCS, G-1.

SECTION A - CONSENT

I, _____ , this _____ day of _____ 20 25 ,
(Client's Full Name)

do hereby voluntarily consent to the release of the following information by HQDA ASAP
(Name of Installation ASAP)

pertaining to my identity, diagnosis, prognosis, or treatment from any Army record maintained in connection with alcohol or other drug abuse education, training, treatment, rehabilitation, or research to Child/Youth Svcs Suitability Prog _____ for the purpose of completing a background check requirement in accordance with Department of Defense Instruction 1402.05 and Army Directive 2014-23.

_____ namely,

*** see above***
(extent or nature of information to be disclosed)

SECTION B - EXPIRATION / REVOCATION
(Check applicable paragraph)

1. ☑ I understand that this consent automatically expires when the above disclosure action has been taken in reliance thereon and that, except to the extent that such action has been taken, I can revoke this consent at any time.

- Or -

(For disclosure to civilian criminal justice officials under the provisions of paragraphs 10-22 and 10-27, AR 600-85)

2. ☐ I understand that this consent automatically expires 60 days from today's date or when my present criminal justice system status changes to _____

Further, I understand that if my release from confinement, probation, or parole is conditioned upon my participation in the ASAP, I cannot revoke this consent until there has been a formal and effective termination or revocation of my release from such confinement, probation, or parole.

SIGNATURE OF CLIENT		DATE
NAME OF WITNESS *(Type or print)*	SIGNATURE	DATE

SECTION C - APPROVAL AUTHORITY FOR RELEASE OF INFORMATION

NOTE: *Other than the MEDCEN/MEDDAC/DHA Commander, approval authority for release of information may be delegated to the Program Physician or the Clinical Director.*

In my judgment, the release of an evaluation of the present or past status of _____
(Client's Name)

in the alcohol or other drug treatment and rehabilitation program will not be harmful to him/her.

NAME OF MEDCEN/MEDDAC/DHA Commander OR DESIGNATED REPRESENTATIVE *(Type or print)*	
SIGNATURE	DATE