

**ARIZONA STATE BOARD OF NURSING  
CANDO PROGRAM  
4747 North 7th Street, Suite 200  
Phoenix, Arizona 85014-3655  
(602) 771-7865      FAX (602) 771-7882**

**CONSENT FOR MUTUAL DISCLOSURE**

Client Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

The undersigned hereby requests and authorizes the exchange and release of information specified below between the CANDO Program for licensed nurses and:

Name/Institution: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

**INFORMATION TO BE RELEASED:**

- |   |                             |
|---|-----------------------------|
| _____ Discharge Summary(s)  | _____ Treatment Progress    |
| _____ Psychological Test Report                                   | _____ Continuing Care Plans |
| _____ Medical Information   | _____ Drug Screen Results   |
| _____ Job Performance   |                             |
| _____ All Information Pertaining To Chemical Dependency Treatment |                             |
| _____ Other: _____  |                             |

**FOR THE PURPOSE(S) OF:**

- |                                |                       |
|--------------------------------|-----------------------|
| _____ Diagnosis and Evaluation | _____ Continuing Care |
| _____ Monitoring Recovery      |                       |
| _____ Other: _____             |                       |

This authorization is subject to my written revocation at any time except to the extent action has been taken in reliance thereon. I understand that neither the provider of the information, nor the recipient shall be liable to me for any consequences of the release or receipt of the information.

Signed this \_\_\_\_\_ day of \_\_\_\_\_ 2010.

\_\_\_\_\_  
Client Signature

Witness: \_\_\_\_\_  
Signature