MT. OLIVE COUNSELING 8c CLINIC
1278 Route 46, Ledgewood, NJ 07852
Ph. 973-584-6700, Fax 973-584-4991

AUTHORIZATION OF RELEASE FOR CONFIDENTIAL INFORMATION

I, --- DO HEREBY CONSENT to and authorize the staff of MT. OLIVE COUNSELING & CLINIC disclose and/or request from, via telephone or in writing, information relating to me to the following Organizations (either an attorney, or anyone affiliated with my treatment, etc.) I understand that my information, which is retained by the MT. OLIVE COUNSELING & CLINIC, may not be disclosed to another person without my authorization. I hereby give authorization to MT. OLIVE COUNSELING & CLINIC to disclose and/or request any and/or all information regarding my treatment (please circle appropriate choice above):

Name of Organization or person:

____ ______________________________

Name **Telephone Number**

____

This authorization automatically expires at discharge or termination of treatment. I understand that upon this expiration date, MT. OLIVE COUNSELING & CLINIC will no longer provide my information to the person stated above, and that if I wish for this person to continue to receive information, I must execute another authorization. I understand that if the above-named person is not a health care provider or part of a health plan covered by federal privacy regulations, my health information may not be re-disclosed to the person and will no longer be protected by these regulations. However, the person named above may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
I understand that if I refuse to sign this form, MT. OLIVE COUNSELING & CLINIC will not disclose my information to the person named above. I understand I may revoke this authorization at any time, in writing, except to the extent MT. OLIVE COUNSELING & CLINIC has acted in reliance on this authorization. A written request to revoke this authorization must be provided to MT. OLIVE COUNSELING & CLINIC. The revocation will be effective on the date MT. OLIVE COUNSELING & CLINIC receives the notification.

Addendum

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Substance Abuse Information Only: Further, I understand that if I am authorizing MT. OLIVE COUNSELING & CLINIC to disclose information about **substance abuse,** I must state the purpose of the disclosure. My purpose in allowing MT. OLIVE COUNSELING & CLINIC to disclose this information is as follows: ____

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I consent for any or all the following information to be released:

	IDO CONSENT (Initial each line)	I DO NOT CONSENT (Initial each line)
1. Addiction Severity Index (ASI)	___________	___________
2. Biopsychosocial Assessment	___________	___________
3. Current Medications	___________	___________
4. Discharge Summary	___________	___________
5. HIV Test Results	___________	___________
6. Medical and Physical Examination	___________	___________
7. Medical Test Results	___________	___________
8. Program Admission/ Discharge	___________	___________
9. Program Attendance	___________	___________
10. Psychiatric or Psychological Evaluation	___________	___________
11. Psychiatric or Psychological	___________	___________
12. Progress/ Reports		
13. Treatment Diagnosis	___________	___________
14. Treatment Plan	___________	___________
15. Treatment Prognosis	___________	___________
16. Treatment Status/ Progress	___________	___________
17. Urine Drug Screen Result	___________	___________
18. Other		

The Federal Regulations (42 CFR Part 2) prohibit any further release of this information in cases of patient's suffering from Mental Health (see below).

Patient Date of Birth __________Patient Signature ______________________ Date ____________

____ ________________________

Parent/legal Guardian or Attorney Signature **Date**

(Copy of Valid Appointment of Guardianship or Power of Attorney must be attached).

________________________________ *Administrative Assistant* ________________

MTOCG Staff Member **Title** **Date**

This information has been disclosed to you from records whose confidentiality is protected by Federal and State law Federal Regulations and Statutes (42 CPR-Part 2) and New Jersey State Statutes (N.J.S.A 26:2B-15) prohibits you from any further disclosure of it without the express written consent of the person to whom it pertains, or as otherwise permitted by such regulations and statutes. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Use separate form for each chain of custody. The form can be duplicated if needed.