Trinity Counseling Service
22 Stockton St., Princeton, NJ 08540
(t) 609-924-0060 (f) 609-924-7436
www.trinitycounseling.org

AUTHORIZATION TO RELEASE OR RECEIVE MEDICAL, PSYCHIATRIC, ALCOHOL, SUBSTANCE USE RECORDS, AND HIV-RELATED INFORMATION

PATIENT INFORMATION:
Patient/Client Name: _____
DOB:_____ SSN:_____ Telephone:_____
Maiden Name/Other Name Used in the past: _____
Dates of treatment covered by this authorization: From _____To _____

EXPLANATION:
This authorization conforms to requirements of State and Federal laws governing release and receipt of Protected/Patient Health Information (PHI).

AUTHORIZATION:
I hereby authorize the following healthcare provider/agency to disclose information from my records to the recipient(s) listed below, even though such information is otherwise confidential and/or privileged.

FROM: Name:_____
Address:_____
City, State, Zip Code:_____

TO: Name:_____
Address:_____
City, State, Zip Code:_____

Re: Self ____ Minor child ____ Other____

INFORMATION TO BE RELEASED OR RECEIVED:
I give **special authorization** to release or receive information regarding:

☐ Substance Abuse ☐ HIV Information ☐ Psychiatric/Mental Health

Disclosure shall include the following types of information. Check all that apply:
___Evaluations/Assessments/Treatment Plans
___Inpatient Records
___Drug Testing Results
___Financial Records
___ASAM Results
___Lab Reports
___Outpatient Records
___Crisis Records
___Prescription/Medication Log
___Other (Please be specific) _____

Exception(s): Information that you **do not** want released or received (Please be specific):

Trinity Counseling Service
22 Stockton St., Princeton, NJ 08540
(t) 609-924-0060 (f) 609-924-7436
www.trinitycounseling.org

AUTHORIZATION TO RELEASE OR RECEIVE MEDICAL, PSYCHIATRIC, ALCOHOL, SUBSTANCE USE RECORDS, AND HIV-RELATED INFORMATION

I understand that such information cannot be released or received without my special consent, except when required by law, and that all restrictions contained in this authorization as to use, transfer, or disclosure of such information apply to such records.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Trinity Counseling Service. I understand that the revocation will not apply to information that has already been released or received in response to this authorization.

***DATE OF EXPIRATION**: _____
*This authorization expires one year from date signed or as otherwise specified.

PROHIBITION OF USAGE, TRANSFER, OR REDISCLOSURE OF INFORMATION: Except as required by state or federal laws, use of information released or received for other than the stated purpose or redisclosure or transfer of this information to any person or entity not named herein is prohibited. An additional written authorization must be obtained for any proposed new use of the information or its redisclosure or transfer of such information. Authorized information may be subject to redisclosure by the recipient and no longer protected by the privacy regulations.

RIGHT OF CLIENT TO RECEIVE A COPY OF AUTHORIZATION:

I understand that I have the right to receive a copy of this signed authorization.

I have received a copy of this authorization. ☐ YES ☐ NO

I understand that authorizing the use of disclosure of the information identified above is voluntary.

_____ _____
Signature of patient/client or legal representative **Date**

If signed by legal representative, authority/relationship to patient:_____

_____
Signature of Witness

MINORS: By federal regulations in drug/alcohol abuse or HIV/AIDS related material both the patient/client and parent, guardian, or other person authorized to act by state law in his/her behalf is required.

EXCEPTIONS: Where minor may consent to treatment by state law, only minor must sign.