Trinity Counseling Service
353 Nassau 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: ______________________________________ ***(If you are the parent/guardian please write only the name of the TCS client)***
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: ___________Trinity Counseling Service________________________________
Address: ____________353 Nassau Street___________________________________
City, State, Zip Code: __Princeton, NJ 08540_______________________________

Please Clearly Print the Name & Address of the party you wish to receive your medical records. Please check:

☐ I authorize the below named person to participate in my psychotherapy session(s).

☐ I authorize phone consultation only with the below named person.

☐ Please forward the requested medical records:

TO: Name: ____
Address: ____
City, State, Zip Code: ____
Phone: ______________________________ Fax: _________________________

Re: Self ____ Minor child ____ Other____

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INFORMATION TO BE RELEASED OR RECEIVED:
I give **special authorization** to release or receive information regarding: ***(please be aware that any items which are not checked CANNOT be included in the record released to the above named)***

☐ Substance Abuse ☐ HIV Information ☐ Psychiatric/Mental Health

Disclosure shall include the following types of information. Check all that apply:
(Sometimes it is helpful to refer to a new provider before requesting all pieces of a record. A new provider may only need specific information or the most recent time period in order to treat a client/patient.)

___Evaluations/Assessments/Treatment Plans
___Lab Reports
___Inpatient Records
___Outpatient Records, including
- Progress Notes
- Termination Summary

___Other (Please be specific) ____

Exception(s): Information that you **do not** want released or received ***(Specifically list below any information or parts of your record that should not be sent to the above named)***:

Please initial here if there are no exceptions __________________

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**: ______________________________ ***(If you want to specify a date on which the release will become invalid. If you do not wish to specify, this authorization expires one year from date signed.)

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.

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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 **Date**

____ ____________________________
Signature of guardian/legal representative (required for clients under 18 years of age) **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.