Affiliates in Clinical Services
"Personal Growth, Integration, Wellness"
305 Roseberry Street, Suite 8 Phillipsburg, New Jersey 08865 Phone (908) 454-7244
Fax (908) 859-2109

# Authorization to Release Health Information Pursuant to HIPAA

**I, _____ , date of birth _____ ,**
(Client full name) (mm/dd/yyyy)
**or my authorized representative, authorize my clinician:**

**( ) Gerard A. Machado, PsyD, ABPP, APRN-BC**
**( ) Linda Beal, MSN, APRN-BC**
**( ) Kevin Kassick, MA, LPC, LCADC**
**( ) Gerald A. Groves, DPH, MD**
**( ) Linda Esposito, PhD, MSN, APRN-BC**
**( ) Michael C. Kenney, MSW, LCSW**
**( ) Pamela M. Cullen, MSW, LCSW**
**( ) Michael K. Ware, MA, LAC**
**( ) Hilary M. Wyant, MA, LAC**

To: ( ) send to ( ) receive from the following agencies or people:

_____
Name

_____
Address City State Zip

_____
Telephone Fax

Health care information regarding my care and treatment to be released as described below:

( ) Entire Record (Documents)
( ) Discussion Only of Entire Record and Documents as Requested
( ) Medical Reports
( ) Progress Reports
( ) Case Notes
( ) Discharge Summary
( ) Recent Lab Reports
( ) Other (specify) _____

The above information will be used for the following purposes:

( ) Planning Appropriate Treatment or Program
( ) Continuing Appropriate Treatment or Program
( ) Determining Eligibility for Benefits or Program
( ) Case Review
( ) Updating Files
( ) Other (specify)_____

I ***specifically authorize*** the release of the following types of highly confidential information: AIDS or HIV, Mental/Behavioral Health, Substance/Alcohol Abuse, and Sexually Transmitted Diseases. I understand that, unless action already has been taken in reliance on this authorization, I may revoke this authorization at any time by making a written request to Affiliates in Clinical Services. I understand that signing this authorization is voluntary. I understand that information disclosed based on this authorization may be subject to redisclosure by the recipient, and no longer protected by federal or state privacy regulations.

Signature of Client _____ Date_____

Signature of Parent/Guardian _____ Date_____

Signature of Witness (if client is unable to sign)_____ Date_____

Signature of Person Informing Client of Rights _____ Date_____