# INTEGRITY, INC.
# AUTHORIZATION FORM

## AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION[1]

I, _____, authorize _____
(Name of client) (Name of entity making the disclosure)

to disclose to _____
(Name of person or organization to which disclosure is to be made)

the following information: (check all that apply)

- ☐ Drug and/or Alcohol Assessment Records
- ☐ Drug and/or Alcohol Treatment Records
- ☐ Mental Health Assessment Records
- ☐ Psychotherapy Notes
- ☐ Admit/Discharge Summary
- ☐ Medical History
- ☐ Medical Exams, Lab Reports
- ☐ Mental Health Treatment Records
- ☐ Other (specify the nature and extent of information to be released):

_____

This information will be used or disclosed for the following authorized purpose:

_____
(Purpose of disclosure, as specific as possible)

☐ **RECIPROCAL RELEASE AUTHORIZATION** (when checked, authorizes two way exchange of information between the above named persons, organizations, and/or alcohol/drug programs)

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this authorization expires automatically as follows:

_____
(Specification of the date, event or condition upon which this authorization expires.)

I understand that once the above information is disclosed, it may no longer be protected by privacy laws if such laws do not apply to the designated recipient, and it may be re-disclosed by the designated recipient.

I have had a full opportunity to read and consider the contents of this authorization form and Integrity Inc.'s Patient Notice. I understand that this authorization is voluntary and that I may refuse to sign this authorization form. I also understand that my refusal to sign will not affect my ability to receive treatment at Integrity.

A photocopy of this authorization is as effective as the original. Unless otherwise agreed to in writing, information may be disclosed under this authorization in any form or medium, including oral, written, or electronic transmission.

I understand that I may revoke authorization by writing to "The HIPAA Privacy Officer" at the following address:
Integrity, Inc., 103 Lincoln Park, Newark, NJ 07102

Dated: _____ _____
(Signature of Client)

Dated: _____ _____
(Signature of Parent or Guardian)

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[1] This form is to be used for basic authorization for disclosing and receiving information between two parties regarding a specific client's information. Effective: 7/17/2003 Revised: 2/23/2006; 6/26/2009; 7/23/2009; 3/26/2010; 4/21/2010; 5/21/2012. 1/30/2015.

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## PROHIBITION ON REDISCLOSURE OF INFORMATION CONCERNING ALCOHOLISM AND SUBSTANCE ABUSE PATIENT

(To Accompany Disclosure of Information made with Authorization of Alcoholism and/or Substance Abuse Client)

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. (42 CFR 2.32).