AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Romy Nesin, Ph.D.
108 Baker Street, Suite 201
Maplewood, NJ 07040
917-418-3870

I, _____, give permission to Romy Nesin, Ph.D. to:
Printed Name

____ DISCLOSE information to: AND/OR ____ OBTAIN information from:

_____
Name

_____
Address

Phone: ( ) _____ Fax: ( ) _____

INFORMATION TO BE DISCLOSED/OBTAINED:
___My Entire Mental Health Record or ___ My Entire Substance Abuse Record; OR

___ Only the following information:

- ___ Substance Abuse
- ____ Progress Report
- ____ Diagnosis/Assessment
- ____ Treatment Recommendations
- ____ Treatment Plan
- ____ Attendance Records
- ____ Other (specify) _____

FORM IN WHICH INFORMATION SHOULD BE RELEASED:
_____ VERBAL ____ WRITTEN ____ PHOTOCOPIED ____ OTHER _____

PURPOSE FOR SUCH DISCLOSURE IS:

- ____ To permit Continuity of Care
- ____ To permit Case Management (including insurance benefits and processing of claims)
- ____ Other (specify) _____

I may revoke this consent at any time except to the extent that action has been taken. If I do not revoke it, this consent will expire one year from the date of my signature.

_____	_____	_____
Signature of client	Printed name	Date
_____	_____	_____
Signature of parent/guardian	Printed name	Date

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are so protected, Federal Regulations (42 CFR Part 2) prohibits 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 this information to criminally investigate or prosecute any alcohol or drug abuse client.