**Release of Information Authorization Form**

Client Full Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize Sea Possibilities Counseling LLC to exchange information with

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

for the purpose of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Contact information for this organization or person is:

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email, if applicable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If for written information, specify documents:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I understand that my health information is protected under the federal regulations governing the confidentiality of alcohol and drug abuse patient records, 42 C.F.R. Part 2, the Health Insurance Portability and Accountability Act (HIPAA) 25 C.F.R. Parts 160 and 164, and the NJ State Privacy Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

 By signing this authorization, I acknowledge:

* This authorization can be revoked in writing at any time by initialing such on this release.
* I have reviewed the Notice of Privacy Practices.
* Revocation of this disclosure does not affect disclosures already made in reliance with this authorization.
* Information disclosed may be subject to re-disclosure by the recipient and not protected under HIPAA or State law.
* I have the right to a copy of this authorization.
* My treatment is not conditional upon signing this release, however, if I refuse it may affect continuity of care.

This form has been fully explained and I certify that I understand its contents.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration one year from signature date unless earlier date identified here: \_\_\_\_\_\_\_\_\_