AFFILIATES IN CLINICAL SERVICES, PC
305 Roseberry Street, Suite 8
Phillipsburg, NJ 08865-1600
(908) 454-7244 – Fax (908) 859-2109

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Name: _____ **Date of Birth:** _____

I, or my authorized representative, authorize my provider:

- ☐ **Gerard A. Machado, PsyD, ABPP, APN-BC**
- ☐ **Linda Beal, MSN, APN-BC**
- ☐ **Kevin Kassick, MA, LPC, LCADC**
- ☐ **Gerald A. Groves, DPH, MD**
- ☐ **Other:** _____
- ☐ **Linda Esposito, PhD, APN-BC**
- ☐ **Michael K. Ware, MA, LPC, NCC-BC**
- ☐ **Lori Vargo Heffner, MA, LPC, LCADC**
- ☐ **Carolyn Regan, PhD**
- ☐ **John P. Shalhoub, LCSW**

To: ☐ **send to** ☐ **receive from the following agencies or people:**

_____
Name

_____ _____ _____ _____
Address City State Zip

_____ _____
Telephone Fax

Release covers entire history unless specified here for specific period of treatment or dates of service: _____

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, or Signature of Parent/Guardian Signature of Witness (if client is unable to sign)

_____ _____
Signature of Person Informing Client of Rights Date Signed