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 agency or person:

____
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:

Discussion Only of Record and Documents Requested
Entire Record (Documents)
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
Continuing Appropriate Treatment
Determine Eligibility for Benefits
Case Review
Updating Files
Other (specify)_____________________

I ***specifically authorize*** the release of the following types of highly confidential information:
Mental/Behavioral Health Substance/Alcohol Abuse AIDS or HIV 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