Willow Tree Counseling Associates, LLC

Client: ___________________________ Letter Date: _________ Expiration Date: _________

Authorization Form for the Release of Confidential Information

I, ____ authorize Willow Tree Counseling Associates LLC to disclose to ____, the following information: (Check all that apply)

___ Alcohol & Drug Assessment ___ Alcohol & Drug Treatment Plan ___ Results of Lab Test ___ An Interpretive Summary
___ Discharge and/or Transition Summary ___ Other: ____

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

___ Assist in the recovery process ___ Providing updates on treatment progress ___ Other: ____________________________

X **RECIPROCAL RELEASE AUTHORIZATION** (When checked, authorizes two-way exchange of information between the above named persons, organizations, and behavioral healthcare organizations.)

I understand that my 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. 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: 90 Days following Termination of Treatment (mandatory for legally mandated clients) X One Year from Date of Signing __ Other (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 Willow Tree Counseling Associates LLC. 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 Willow Tree Counseling Associates LLC, 213 Village Road, Green Village, NJ 07935.

Signature of Client _________________________________ Client Signature Date: _________________

Signature of Staff Member ___________________________ Staff Signature Date: _________________

This form is to be used for basic authorization for disclosing and receiving information between two parties regarding a specific client's information. Effective: 3/1/17

PROHIBITION ON REDISCLOSURE OF INFORMATION CONCERNING ALCOHOLISM & 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 restric investigate or prosecute any alcohol or drug abuse patient. (42 CFR 2.3) 2).