State of New Jersey
Department of Human Services
P.O. BOX 700
Trenton NJ, 08625

Authorization to Disclose Information

I, _____ understand that my information, which is retained by the New Jersey State Department of Human Services and/or one of its agencies, may not be disclosed to a third party without my expressed written authority, unless permitted or required by law. I hereby authorize the New Jersey State Department of Human Services to disclose my information to:

Individual's Name or Class of Individuals _____

_____

Organization/Entity (if applicable): _____

Address: _____

Telephone Number: _____ **Fax Number**: _____

Describe the information to be disclosed. (Check all that apply):

[ ] Entire medical record

[ ] Partial medical record

[ ] Demographic information

[ ] Other information

Identify the specific information to be disclosed. (Please use descriptors, including but not limited to dates, services, level of detail to be released, etc.)

This authorization shall be in force and effect until: _____
Date or Event of Expiration

_____, at which time this Authorization expires. I understand that upon this expiration date, the New Jersey State Department of Human Services will no longer provide my information to the person or persons stated above, and that if I wish for this person or persons to continue to receive information, I must execute another authorization.

I understand that:

- I have the right to revoke this Authorization, in writing, at any time, except to the extent the New Jersey State Department of Human Services has taken action in reliance on this authorization. The process of and exceptions to revocation are fully detailed in the DHS Notice of Privacy Practices. The effective date of the revocation is the date on which the revocation was received by a Department employee.
- Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Department of Human Services, federal law or state law.
- The person or class of persons named above may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality requirements.
- This Department and its agencies will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.
- If I am authorizing the disclosure of my **substance abuse information**, I must state the purpose of the disclosure. My purpose in allowing the Department to disclose this information is as follows:

_____

_____

By signing below, I fully acknowledge and agree to the above terms.

_____ _____

Signature of Individual or Personal Representative

Date

If you wish to file a complaint with our agency or get more information on how you can file a complaint with the Department of Human Services, please contact the Privacy Officer in the Office of Legal & Regulatory Affairs, P.O. Box 700 Trenton, NJ 08625, or the Office of Civil Rights, US Department of Health & Human Services, 26 Federal Plaza-Suite 3312, New York, NY 10278.

FOR OFFICE USE ONLY*:*

Date received _____