JOURNEY'S EDGE COUNSELING, LLC
Outpatient Behavioral Health • Substance Use & Co-Occurring Disorders

AUTHORIZATION FOR RELEASE OF INFORMATION

CLIENT INFORMATION

Client Full Name

Date of Birth

Address

Phone Number

DIRECTION OF DISCLOSURE

I authorize Journey's Edge Counseling, LLC to:

☐ RELEASE information TO the party named below

☐ OBTAIN information FROM the party named below

Name / Organization

Phone / Fax

Address

PURPOSE OF DISCLOSURE

INFORMATION TO BE DISCLOSED (check all that apply)

☐ Diagnosis

☐ Treatment / Progress Notes

☐ Treatment Plan

☐ Psychiatric Records

☐ Substance Use Treatment Records

☐ Psychological Testing Results

☐ Lab / Toxicology Results

☐ Discharge Summary

☐ Other:

Records Covering Dates From

To

21 Main Street, Second Floor, Office D, Sparta, NJ 07871
Phone: (973) 832-0869 | Fax: (973) 695-1381 | dr.bob@journeysedgecounseling.com
Robert Florian, PhD, LCADC, CAADC • LCADC License #37LC00404200

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EXPIRATION OF THIS AUTHORIZATION

This authorization will expire on the date indicated below, or, if left blank, one (1) year from the date signed, whichever occurs first.

Expiration Date (optional)

ACKNOWLEDGMENT

I understand that I may revoke this authorization at any time by submitting a written request to Journey's Edge Counseling, LLC, except to the extent that action has already been taken in reliance on it. I understand that treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization, except as permitted by law. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and, once disclosed, may no longer be protected by applicable privacy regulations, except where protected under 42 CFR Part 2 as described below.

NOTICE OF PROHIBITION ON REDISCLOSURE (42 CFR PART 2)

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 information in this record that identifies a patient as having or having had a substance use disorder, whether or not recorded, 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 restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as expressly authorized by a court order.

SIGNATURE

Signature of Client / Legal Guardian

Date

Printed Name

Relationship to Client (if not self)

Witness Signature (optional)

Date

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