

SEASHORE FAMILY SERVICES OF NEW JERSEY

270 Chambers Bridge Rd., Suite 10
Brick, NJ 08723
Phone (732) 920-2700
Fax: (732) 262-0707

226 Main St.
Toms River, NJ 08753
Phone (732) 244-1600
Fax: (732) 349-5532

35 Beaverson Blvd Bldg 8 Suite 8A
Brick, NJ. 08723
Phone: (732) 920 - 2700
Fax: (732) 477 - 3527

Consent For the Release of Confidential Information

I, _____, authorize
(Name of Client)

Seashore Family Services of New Jersey to disclose to/from
(Name or general designation of alcohol/drug program making disclosure)

(Name and Title of Person and Organization to which the Disclosure is to be made.)

The following information:

(Nature and amount of information to be disclosed; as limited as possible)

The purpose of the disclosure authorized in this is to:

Assist client to satisfy treatment requirements, to coordinate case management and reimbursement
(Purpose of disclosure, as specific as possible)

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, (42 CFR-Part 2), and the Health Insurance Portability and Accountability Act of 1996 (“HIPPA”), 45 C.F.R. parts 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 consent in writing at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as follows:

(Specification of the date, event or condition upon which this consent expires)

I understand that generally Seashore Family Services of New Jersey may not condition my treatment on whether I sign a consent form, by that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

Client’s Name (print) Client’s Signature Date

Witness’s Name (print) Witness’s Signature Date