Maryville
INTEGRATED CARE

Release of Information Form

Please mail this form to: Maryville, Records Department, 1903 Grant Ave., Williamstown, NJ 08094; email at records@maryvillenj.org; or fax to 856-629-3760 for Williamsown or 609-283-0262 for Maryville at Post House in Pemberton. If you have questions, please call 856-629-0244, ext. 313.

Patient Name: _____

Date of Birth: _____ Last 4 digits of SSN: _____

I do hereby consent and authorize Maryville, Inc.'s employees and agents to communicate reciprocally with:

Name: _____ Organization: _____

City: _____ State: _____ Zip: _____

Phone: _____ E-mail: _____

Purpose of disclosure: treatment and/or _____

Information to be released:		***Please initial each line*** .	
		I Do Consent	**I DO NOT consent**
1.	Addiction Severity Index (ASI)	1 _____	1 _____
2.	Biopsychosocial assessment	2 _____	2 _____
3.	Current medications	3 _____	3 _____
4.	Current medications except _____	4 _____	4 _____
5.	Discharge summary	5 _____	5 _____
6.	HIV test results	6 _____	6 _____
7.	Medical & physical examinations	7 _____	7 _____
8.	Medical test results	8 _____	8 _____
9.	Admission & discharge dates	9 _____	9 _____
10.	Program attendance	10 _____	10 _____
11.	Psychiatric or psychological evaluation	11 _____	11 _____
12.	Psychiatric or psychological progress & results	12 _____	12 _____
13.	Treatment diagnoses	13 _____	13 _____
14.	Treatment plan	14 _____	14 _____
15.	Treatment prognosis	15 _____	15 _____
16.	Treatment status & progress	16 _____	16 _____
17.	Photo identification	17 _____	17 _____
18.	Certificate of completion	18 _____	18 _____
19.	_____	19 _____	19 _____
20.	_____	20 _____	20 _____

I 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 except if authorization was a condition of a court order, probation, or parole placement. In these cases, Maryville, Inc. is authorized to continue to communicate with the identified court officers up to and including discharge from treatment. This consent will remain in force for a period of _____ days from the date below, not to exceed one year, in order to carry out the purpose for which it was given.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act (HIPAA) and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that refusal to sign will not prevent me from being admitted to Maryville, Inc.'s treatment services unless I have been mandated to treatment by a judicial process.

Patient signature: _____ Date: _____

Witness signature: _____ Date: _____