



Consent to Treatment Form

I, _____ give Team Management 2000 Inc. permission to provide me with clinical, substance abuse treatment, and/or case management services. I understand that my records are protected under the Federal Regulations Governing Confidentiality of Alcohol and Drug Abuse Patient Records Act, 42 C.F.R. Part 2, and have been made aware of the exceptions to these regulations.

Signature of Patient/Client, or
Person permissible by Law to give consent

Date _____



ACKNOWLEDGEMENT

I, hereby acknowledge that I have received and read the client handbook. I acknowledge that the information contained in this handbook has been explained to me.

Client Signature

Date

Counselor Signature

Date



Appendix –Part54a-Model Notice of individuals Receiving Substance Abuse Services

Model Notice to Individuals Receiving Substance Abuse Services

No provider of substance abuse services receiving federal funds from the U.S. Substance Abuse and Mental Health Services Administration, including this organization, may discriminate against you on the basis of religion, a religion belief, a refusal to hold religious belief, or a refusal to actively participate in a religious practice.

If you object to the religious or non-religious character of this organization, Federal law gives you the right to a referral to another provider of substance abuse services. The referral, and your receipt of alternative services, must occur within a reasonable period of time after you request them. The alternative provider must be accessible to you and have the capacity to provide substance abuse services. The services provided to you by the alternative provider must be of a value of the services you would have received from the organization.

Client Signature

Date

Counselor signature

Date



84 Main Street
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P# (201) 487-4700
F# (201) 487-4787

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F# (973) 324-2284

972 Broad Street, 3rd Fl
Newark, NJ 07102
P# (973) 273-0425
F# (973) 273-0428

HIPPA NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996-(HIPAA) Health Information Technology for Economic and Clinical Health Act (HITECH Act), and associated regulations and amendments.

This notice describes how health information about you may be used and disclosed, and how you can get access to this information.

ABOUT THIS NOTICE

We understand that health information about you is personal and we are committed to protecting your information. We create a record of the care and services you receive at all divisions of **Team Management 2000 Inc.** We need this record to provide care (treatment), for payment of care provided, for health care operations, and to comply with certain legal requirements. This Notice will tell you about the ways in which we may use and disclose health information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of health information. We are required by law to follow the terms of this Notice that is currently in effect.

WHAT IS PROTECTED HEALTH INFORMATION ("PHI")

PHI is information that individually identifies you. We create a record or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse that relates to:

- Your past, present, or future physical or mental health or conditions,
- The provision of health care to you, or
- The past, present, or future payment for your health care.

HOW WE MAY USE AND DISCLOSE YOUR PHI

We may use and disclose your PHI in the following circumstances:

- **Treatment.** We may use or disclose your PHI to give you medical treatment or services and to manage and coordinate your medical care. For example, your PHI may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.
- **Payment.** We may use and disclose your PHI so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.
- **Health Care Operations.** We may use and disclose PHI for our health care operations. For example, we may use your PHI to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.



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- **Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services.** We may use and disclose PHI to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.
- **Minors.** We may disclose the PHI of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.
- **Research.** We may use and disclose your PHI for research purposes, but we will only do that if the research has been specially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your PHI. Even without that special approval, we may permit researchers to look at PHI to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any PHI. We may disclose PHI to be used in collaborative research initiatives amongst Be Well Medical Center providers. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. However, we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contact any individual.
- **As Required by Law.** We will disclose PHI about you when required to do so by international, federal, state, or local law.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose PHI when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.
- **Business Associates.** We may disclose PHI to our business associates who perform functions on our behalf or provide us with services if the PHI is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your PHI.
- **Military and Veterans.** If you are a member of the armed forces, we may disclose PHI as required by military command authorities. We also may disclose PHI to the appropriate foreign military authority if you are a member of a foreign military.
- **Workers' Compensation.** We may use or disclose PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.
- **Public Health Risks.** We may disclose PHI for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; and (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- **Abuse, Neglect, or Domestic Violence.** We may disclose PHI to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.



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- **Health Oversight Activities.** We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Data Breach Notification Purposes.** We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your health information.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We also may disclose PHI in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your PHI to defend ourselves in the event of a lawsuit.
- **Law Enforcement.** We may disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes.
- **Military Activity and National Security.** If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your PHI to authorized officials so they may carry out their legal duties under the law.
- **Coroners, Medical Examiners, and Funeral Directors.** We may disclose PHI to a coroner, medical examiner, or funeral director so that they can carry out their duties.
- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose PHI to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.
- **Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out**
 - **Individuals Involved in Your Care.** Unless you object in writing, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.
 - **Payment for Your Care.** Unless you object in writing, you can exercise your rights under HIPAA that your healthcare provider not disclose information about services received when you pay in full out of pocket for the service and refuse to file a claim with your health plan.
 - **Disaster Relief.** We may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.
 - **Fundraising Activities.** We may use or disclose your PHI, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications.



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Your Written Authorization if Required for Other Uses and Disclosures

The following uses and disclosures of your PHI will be made only with your written authorization:

- Most uses and disclosures of psychotherapy notes,
- Uses and disclosures of PHI for marketing purposes; and
- Disclosures that constitute a sale of your PHI.

Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose PHI under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Rights Regarding Your PHI

You have the following rights, subject to certain limitations, regarding your PHI:

- **Inspect and Copy.** You have the right to inspect, receive, and copy PHI that may be used to make decisions about your care or payment for your care. We have up to 30 days to make your PHI available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. You can only direct us in writing to submit your PHI to a third party not covered in this notice. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.
- **Summary or Explanation.** We can also provide you with a summary of your PHI, rather than the entire record, or we can provide you with an explanation of the PHI which has been provided to you, so long as you agree to this alternative form and pay the associated fees.
- **Electronic Copy of Electronic Medical Records.** If your PHI is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. If the PHI is not readily producible in the form or format you request your record will be provided in a readable hard copy form.
- **Receive Notice of a Breach.** You have the right to be notified upon a breach of any of your unsecured PHI.
- **Request Amendments.** If you feel that the PHI we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
- **Accounting of Disclosures.** You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your PHI. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. The first accounting of disclosures you request within any 12- month period will be free. For additional



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requests within the same period, we may charge you for the reasonable costs of providing the list. We will tell you what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

- **Request Restrictions.** You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment, or health care operations. We are not required by federal regulation to agree to your request. If we do agree with your request, we will comply unless the information is needed to provide emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer. Your request must state the specific restriction requested, whether you want to limit our use and/or disclosure; and to whom you want the restriction to apply.

- **Request Confidential Communications.** You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you.

- **Paper Copy of This Notice.** You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may obtain a copy of this Notice by visiting our website: www.doctorbewell.com or contact the Be Well Medical Center office you are receiving services from.

- **Changes to This Notice**

We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for PHI we already have as well as for any PHI we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

- **Complaints**

If you believe your privacy rights have been violated, you may file a complaint with the Team Management 2000 Inc. Privacy Officer, at the address listed at the beginning of this Notice or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave., S.W., Washington, D.C. 20201. Call (202) 619-0257 (or toll free (877) 696-6775) or go to the website of the Office for Civil Rights, www.hhs.gov/oci/hipaa/, for more information. You will not be penalized for filing a complaint.

Notice Effective 1/1/17

**TEAM MANAGEMENT 2000 Inc.
ACKNOWLEDGEMENT OF RECEIPT OF
PATIENT NOTICE OF PRIVACY PRACTICES**

I acknowledge that I read and/or received a copy of the Team Management 2000 Inc. Patient Notice of Privacy Practices effective January 1, 2017.

Date: _____ Patient Signature: _____
(or Guardian, if applicable)



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PATIENT/CLIENT BILL OF RIGHTS

We are partners in your healthcare process. Here's what you can expect from us:

1. We will provide assistance, including an interpreter if you for any reason do not understand or you need help.
2. We will provide you treatment without discrimination as to race, color, religion, sex, national origin, disability, sexual orientation or source of payment.
3. We will provide considerate and respectful care in a clean and safe environment free of unnecessary restraints.
4. We will provide you with emergency care if you need it.
5. We will provide you of the name and position of the doctor/clinical staff who will be in charge of your care in the facility.
6. We will provide you the names, positions and functions of any facility staff involved in your care and you can refuse their treatment, examination or observation.
7. We will provide you with a smoke free environment.
8. We will explain things in ways you can understand about your diagnosis, treatment and prognosis.
9. We will provide you all the information you need to give informed consent for any proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment.
10. We will provide you with all the information you need to give informed consent for an order not to resuscitate. You also have the right to designate an individual to give this consent for you if you are too ill to do so. If you would like additional information, please ask for a copy of the pamphlet "Do Not Resuscitate Order – A Guide for Patients and Families"
11. We encourage you to be involved in making decisions about your care. And we will respect your right to request or refuse medical treatment and be told what effect this may have on your health.
12. We will provide you with a full explanation in deciding whether or not to participate in research. You have the right to refuse to take part in the research.
13. We will care for you in a careful and gentle manner that preserves dignity and contributes to a positive self-image. You have the right to privacy while in the facility and confidentiality of all information and records regarding your care.
14. We encourage your active participation in all decisions about your treatment and discharge from the facility. We will provide you with a written discharge plan and written description of how you can appeal your discharge.
15. We will provide you a review of your medical record/ client file without charge. We can provide a copy of your medical record for which Team Management 2000 Inc. can charge a reasonable fee. You cannot be denied a copy solely because you cannot afford to pay.
16. We will provide you with an itemized bill and explanation of all charges if applicable.



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17. We will work to solve any concerns you may have. You have the right to complain without fear of reprisals about the care and services you are receiving and to have the facility respond to you and if you request it, a written response. Please ask any member of your healthcare team, and we will work promptly to resolve any concerns about your healthcare. You may contact our main offices at (201) 487-4700 to assist you with concerns that you may not feel comfortable discussing with the health care team/or case management team.
18. We will honor any authorized family members and other adults who you give priority to visit consistent with your ability to receive visitors.
19. We encourage you to make known your wishes in regard to anatomical gifts. You may document your wishes in your health care proxy or on a donor card, available from the facility.

Patient/Family Responsibilities We consider you a part of our team of care. Here is what we expect when you visit:

1. You must provide us with complete and accurate information about present complaints, past illnesses, facilityizations, medications and other matters relating to your health.
2. You have the responsibility for asking questions when something is unclear and to report any unexpected changes in your condition to the physician.
3. You must follow the instructions of nurses and allied health personnel as they carry out the coordinated plan of care and implement the responsible practitioner's orders.
4. You are responsible for keeping appointments and must notify the responsible practitioner or the facility if you cannot do so for any reason.
5. You are responsible for your actions if you refuse treatment or do not follow the practitioner's instructions.
6. You must follow our organization's rules and regulations.
7. You must show respect for the people taking care of you and the rights of other patients by assisting in the control of noise, smoking and the number of visitors. You must be respectful of the property of other persons and of the facility.
8. You must meet your financial obligation (if applicable) to the organization, and if you have concerns about doing so, let us know by contacting our main offices at (201) 487-4700.

I have read, understand, and accept the terms outlined in the above "Patient Bill of Rights" document.

(Sign and Date): _____

**Records Release Authorization
Consent for the Release of Confidential Information**

I, _____ DOB _____, hereby give permission to Team Management 2000 Inc. to release and share from my files, with the following (Pharmacist Name) _____ information: **intake evaluation, attendance, treatment progress, prognosis, diagnosis and discharge planning and all medical & criminal arrest background and history.**

This information is to be released to **Contact Name:** _____
Contact Telephone Number: _____
Fax Number: _____

The purpose or need for such disclosure is to: **establish eligibility, determine the appropriate level of care, develop a comprehensive Life Mapping Accountability Plan and to aid in the coordination of services.**

This information may be given as needed either: **verbally, in writing or by facsimile.** I understand that my records are protected under the Federal regulations governing Confidentiality and Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 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: **(1) year after the termination of "Treatment Discharge Plan" I do hereby consent to and authorize all the below listed Partners of Team Management and Ryan White to access information pertinent to my plan.**

****Consent to Release Photo Images and/or Video Footage**

____ Yes, I do give ____ No, I do not give consent to Team Management 2000 Inc. to utilize photo images and video footage of myself, for educational, marketing and promotional purposes via: workshops, company website, announcements, newsletters, brochures, social media outlets, and the like. The use of these photos images and video footage will not compromise the confidential nature of my treatment, services received, or mental/physical health status unless otherwise approved by myself.

(Patient/Client's signature) _____ **Date** _____

Please write decline on signature line above if individual does not grant permission.

*****I grant additional permission for special images and footage disclosing my mental/physical health status and/or treatment and services received to be utilized by Team Management 2000 Inc. for educational, marketing and promotional purposes via: workshops, company website, announcements, newsletters, brochures, social medical outlets, and the like.**

(Patient/Client's signature) _____ **Date** _____

Please write decline on signature line above if individual does not grant permission.

Team Management 2000, Inc. Ryan White EMA-Essex County	Bergen, Passaic & Essex County Jails, NSP	Bergen, Passaic and Essex County Probation
Bergen, Passaic and Essex County WIB	Essex County One-Stop	New Jersey State Parole Board, Drug Court, Probation, Parole
UMDMJ-MEDICAL ST. MICHAELS	NJ Division of Addiction Services	Substance Abuse Mental Health Services Administration
County Participating Hospitals, Bergen & Essex County Health Department St.Bridget's	ESSEX COUNTY HOUSING	Participating Substance Abuse Facilities: Integrity House, Straight & Narrow, St Claire's, Turning Point, ETC

CONFIDENTIALITY STATEMENT- This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibits you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

SIGNATURE OF CLIENT OR PERSON AUTHORIZED BY LAW TO GIVE CONSENT	DATE
SIGNATURE OF WITNESS	DATE

**Records Release Authorization
Consent for the Release of Confidential Information**

I, _____ DOB _____, hereby give permission to Team Management 2000 Inc. to release and share from my files, with the following (Facility Name) _____ information: **intake evaluation, attendance, treatment progress, prognosis, diagnosis and discharge planning and all medical & criminal arrest background and history.**

This information is to be released to _____

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(Patient/Client's signature) _____ Date _____

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UMDMJ-MEDICAL ST. MICHAELS	NJ Division of Addiction Services	Substance Abuse Mental Health Services Administration
County Participating Hospitals, Bergen & Essex County Health Department St.Bridget's	ESSEX COUNTY HOUSING	Participating Substance Abuse Facilities: Integrity House, Straight & Narrow, St Claire's, Turning Point, ETC

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**SIGNATURE OF CLIENT OR
PERSON AUTHORIZED BY LAW TO GIVE CONSENT**

DATE

SIGNATURE OF WITNESS

DATE

**Records Release Authorization
Consent for the Release of Confidential Information**

I, _____ DOB _____, hereby give permission to Team Management 2000 Inc. to release and share from my files, with the following (Physician Name) _____ information: **intake evaluation, attendance, treatment progress, prognosis, diagnosis and discharge planning and all medical & criminal arrest background and history.**

This information is to be released to **Contact Name:** _____

Contact Telephone Number: _____

Fax Number: _____

The purpose or need for such disclosure is to: **establish eligibility, determine the appropriate level of care, develop a comprehensive Life Mapping Accountability Plan and to aid in the coordination of services.**

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_____ SIGNATURE OF CLIENT OR PERSON AUTHORIZED BY LAW TO GIVE CONSENT	_____ DATE
_____ SIGNATURE OF WITNESS	_____ DATE

**Records Release Authorization
Consent for the Release of Confidential Information**

I, _____, DOB _____, hereby give permission to Team Management 2000 Inc. to release and share from my files, with the following (**Emergency Contact**) _____ information: **intake evaluation, attendance, treatment progress, prognosis, diagnosis and discharge planning and all medical & criminal arrest background and history.**

This information is to be released to _____

The purpose or need for such disclosure is to: **establish eligibility, determine the appropriate level of care, develop a comprehensive Life Mapping Accountability Plan and to aid in the coordination of services.**

This information may be given as needed either: **verbally, in writing or by facsimile.**

I understand that my records are protected under the Federal regulations governing Confidentiality and Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 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: **(1) year after the termination of "Treatment Discharge Plan" I do hereby consent to and authorize all the below listed Partners of Team Management and Ryan White to access information pertinent to my plan.**

****Consent to Release Photo Images and/or Video Footage**

_____ **Yes, I do give** _____ **No, I do not give** consent to Team Management 2000 Inc. to utilize photo images and video footage of myself, for educational, marketing and promotional purposes via: workshops, company website, announcements, newsletters, brochures, social media outlets, and the like. The use of these photos images and video footage will not compromise the confidential nature of my treatment, services received, or mental/physical health status unless otherwise approved by myself.

(Patient/Client's signature) _____

_____ Date

Please write decline on signature line above if individual does not grant permission.

*****I grant additional permission for special images and footage disclosing my mental/physical health status and/or treatment and services received to be utilized by Team Management 2000 Inc. for educational, marketing and promotional purposes via: workshops, company website, announcements, newsletters, brochures, social medical outlets, and the like.**

(Patient/Client's signature) _____

_____ Date

Please write decline on signature line above if individual does not grant permission.

Team Management 2000, Inc, Ryan White EMA-Essex County	Bergen, Passaic & Essex County Jails, NSP	Bergen, Passaic and Essex County Probation
Bergen, Passaic and Essex County WIB	Essex County One-Stop	New Jersey State Parole Board, Drug Court, Probation, Parole
UMDMJ-MEDICAL ST. MICHAELS	NJ Division of Addiction Services	Substance Abuse Mental Health Services Administration
County Participating Hospitals, Bergen & Essex County Health Department St.Bridget's	ESSEX COUNTY HOUSING	Participating Substance Abuse Facilities: Integrity House, Straight & Narrow, St Claire's, Turning Point, ETC

CONFIDENTIALITY STATEMENT- This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibits you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

**SIGNATURE OF CLIENT OR
PERSON AUTHORIZED BY LAW TO GIVE CONSENT**

DATE

SIGNATURE OF WITNESS

DATE



Client Name:

DOB:

Date of Admission:

Emergency Contact Information:

Name of Emergency Contact:

Address:

Telephone Number:

Relationship:

Pharmacy Information

Name of Pharmacy:

Address:

Telephone Number:

Medications: