RECOVERY INNOVATIONS, Inc.

Reciprocal Consent to Release Confidential Information

I, ____ (SS #: _____________________________), hereby grant permission for Recovery Innovations, Inc. (RI) to release information to the parties listed below. I also give permission for the parties listed below to release the same information to RI:

______ NJ DAS; DAS-Appointed Fiscal Agent	Atty: ____
______ Redwood Toxicology Laboratory	Prior Tx.: ____________________________________
______ State Drug Court Teams / AOC	Family: ______________________________________
______ WFNJ SAI / NCADD; Medicaid / Unisys	Employer: ____________________________________
______ DYFS / NJ Superior Courts, Family Division	S/O: ____
______ US PTI / US Probation / Federal Courts	Doctor: ______________________________________
______ NJ Parole / Behavioral Interventions	Insurance Co.: _________________________________
______ Monmouth County Probation Division	School: ______________________________________
______ Monmouth County IDRC	Other: _______________________________________
______ Garden Pharmacy	Other: _______________________________________

All information below, unless crossed off, may be released between the parties listed above and may be transmitted via the **regular mail, electronically, by facsimile, or telephonically**:

Treatment Information: All assessments (written & oral), treatment dates, treatment plan, attendance record, treatment status/response, alcohol/drug test results, discharge summary.	Medical Information: All test results including HIV status; lab results, current diagnosis and treatment plan; past / current medications; prognosis; all past medical records; response to and compliance with treatment.
Legal Information: Entire legal history, current charges, dates of DWI, attorney information.	Other: _______________________________________

This release is intended to be reciprocal for both parties. The purpose for this information to be released and/or obtained is **to disseminate / share pertinent clinical and/or medical information to listed parties in order to best coordinate treatment efforts.** This information may be given **as needed.** I understand that this consent can be revoked at any time, in writing, except to the extent that action has been taken in reliance thereon. Otherwise, this consent will expire **one year after discharge from treatment or one year from the date signed below, whichever is later**.

Federal regulations (42 CFR – Part 2) prohibit disclosing information mentioned in this release for any other purpose than intended without the specific written consent of the person to whom it pertains, or as otherwise permitted in such regulations. A General Authorization for the release of medical or other information is NOT sufficient for this purpose. This consent has been given freely and voluntarily.

I understand that treatment services are not dependent upon my decision concerning the release of this information. The benefits and disadvantages of having this information released have been explained to me in clear, understandable language. My signature below indicates that I have read, understand, and agree to the contents of this consent form, and that I have been offered a copy of this document.

Client: ____ Date: _________________

Witness: ____ Date: _________________