State of New Jersey
Department of Human Services
AUTHORIZATION TO DISCLOSE INFORMATION

I understand that my information, which is retained by the **New Jersey State Department of Human Services or one of its divisions**, may not be disclosed to another person without my express written authority. I hereby give authority to the New Jersey State Department of Human Services to disclose any and all information regarding:

***Individual's Name (Print)**:_____

***Date of Birth**:_____

To the following individual:

_____ _____
***Name** ***Telephone Number**

_____ _____
***Name of Organization** Fax Number

_____
***Address**

_____
***City/State/Zip**

This authorization expires on _____ or one year from the date signed, below, which ever is less. I understand that upon this expiration date, the New Jersey State Department of Human Services will no longer provide my information to the person stated above, and that if I wish for this person to continue to receive information, I must execute another authorization.

I understand that if the above-named person is not a health care provider or part of a health plan covered by federal privacy regulations, my **health** information may be re-disclosed by the person I have named above and will no longer be protected by these regulations. However, the person named above may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand that if I refuse to sign this form, the New Jersey State Department of Human Services will not disclose my information to the person named above.

I understand I may revoke this authorization at any time, in writing, except to the extent the New Jersey State Department of Human Services has taken action in reliance on this authorization. The written request to revoke this authorization must be provided to the New Jersey State Department of Human Services employee who received this Authorization. The revocation will be effective on the date that the New Jersey State Department of Human Services employee who received this Authorization receives the revocation.

Substance Abuse Information Only: Further, I understand that if I am authorizing the New Jersey State Department of Human Services to disclose information about **substance abuse**, I

must state the purpose of the disclosure. My purpose in allowing the Department to disclose this information is as follows:

_____

_____

_____.

***Signature (or mark) of Individual, Parent of Minor Child, Legal Guardian or Attorney-in-Fact**:

_____

***Date of Signature**: _____ ***Telephone Number:** _____

Name of Parent of Minor Child, Legal Guardian or Attorney-in-Fact (if applicable):

_____

Copy of Valid Appointment of Guardianship or Power of Attorney must be attached.

If a mark is provided in place of a signature, above, the mark must be witnessed:

Witness Signature (if applicable):_____

Witness Name/Title:_____

***Division(s) Individual Receives Services From (circle all that apply):**

Youth & Family Services (DYFS) ☐ Developmental Disabilities ☐

Blind & Visually Impaired ☐ Medical Assistance & Health Services (Medicaid) ☐

Family Development (Welfare, etc) ☐ Deaf & Hard of Hearing ☐

Mental Health Services ☐ Office of Education ☐ Disability Services ☐

***Denotes information that is required.**