**National Council on Alcohol and Drug Dependence-New Jersey, Inc.**

**Acknowledgement of Uses and Disclosures of**

**Protected Health Information**

This acknowledgement summarizes the uses and disclosures of my protected health information (PHI), including substance use disorder related information that the National Council on Alcohol and Drug Dependence–New Jersey, Inc. (NCADD-NJ) may make throughout my participation with the NCADD-NJ as set forth in the Notice of Privacy Practices. I understand that NCADD-NJ reserves the right to change this notice at any time as provided for in the Notice of Privacy Practices.

I understand that my PHI will be used and shared by NCADD-NJ personnel for my assessment, diagnosis, referrals and other care coordination and case management activities related to my alcohol and/or drug treatment, and/or mental health treatment, and care or related services that I receive from providers, facilities and programs while participating with NCADD-NJ. I understand that NCADD-NJ may be permitted to share my PHI with certain individuals, organizations and agencies with which it has written agreements requiring them to safeguard my information, such as health care service providers. At all times, I understand that NCADD-NJ will use and disclose my PHI only as set forth in its Notice of Privacy Practices. I understand that NCADD-NJ may not otherwise use or disclose any of my PHI without my written consent unless permitted by law.

I understand that my records are protected under the federal regulations governing confidentiality of Substance Use Disorder Patient Records, 42 CFR Part 2, and Protected Health Information under the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations thereunder, including 45 C.F.R. Parts 160 and 164, as well as state confidentiality laws and regulations. I understand that if NCADD-NJ discloses my PHI, pursuant to my written consent or as otherwise permitted or required by law, the information may be subject to re-disclosure by the third-party and may not be protected by applicable federal and state laws and regulations.

I understand that I am not required to sign this acknowledgement in order to obtain treatment. If I refuse to sign this acknowledgement, NCADD-NJ may continue to use and disclose my PHI to the extent permitted and required by law.

By signing below, I hereby agree to and acknowledge that I understand the uses and disclosures of my protected health information by NCADD-NJ as set forth in its Notice of Privacy Practices:

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Signature of recipient (or authorized representative) / date

# Acknowledgement of Receipt of Notice of Privacy Practices:

# Please initial to indicate that you have received a copy of our Notice for review. \_\_\_\_\_\_\_