INTEGRITY, INC.
AUTHORIZATION FOR PROMOTIONAL DISCLOSURE FORM

AUTHORIZATION FOR THE RELEASE
OF CONFIDENTIAL INFORMATION[1]

I, _____, authorize
(Name of member)

Integrity, Inc., to take and use photographs or films of me, and/or interview me for the following event and or publication:

_____
(Specification of the nature and date of event or publication)

for the purpose(s) of:

- □ Publicity
- □ Education/Educational Materials
- □ Marketing
- □ Public Awareness/Advocacy
- □ Radio
- □ Video
- □ Other: _____
- □ Advertising
- □ Fundraising
- □ Internal Publication
- □ External Publication
- □ Television
- □ Internet
- □ Advertising

[Check the appropriate box which applies]
□ My name may be used and disclosed. □ My name may not be used and disclosed.

I understand and agree that the content of such photographs, films and/or interviews will disclose directly or indirectly the fact that I have been a member of Integrity and may contain private health information including references to drug and/or alcohol abuse and drug and/or alcohol treatment information.

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse 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 authorization unless otherwise provided for by the regulations. I also understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this authorization expires automatically as follows:

_____
(Specification of the date, event or condition upon which this authorization expires.)

I understand that once the above information is disclosed, it may no longer be protected by privacy laws if such laws do not apply to the designated recipient, and it may be re-disclosed by the designated recipient.

I have had a full opportunity to read and consider the contents of this authorization form. I understand that this authorization is voluntary and that I may refuse to sign this authorization form. I also understand that my refusal to sign will not affect my ability to receive treatment at Integrity.

A photocopy of this authorization form is as effective as the original. Unless otherwise agreed to in writing, information may be disclosed under this authorization in any form or medium, including oral, written, or electronic transmission.

I understand that I may revoke authorization by writing to "The HIPAA Privacy Officer" at the following address:
Integrity, Inc., 103 Lincoln Park, Newark, NJ 07102

Dated: _____ _____
(Signature of Member)

Dated: _____ _____
(Signature of Parent or Guardian)

[1] This form is to be used for authorization to disclose an individual's name, electronic and/or photographic images, and participation in an Integrity program in promotional literature which shall become public information with no limitations on distribution. Effective: 7/17/2003 Revised: 4/14/2006; 6/26/2009; 7/24/2009; 3/26/2010; 4/21/2010