



**CONSENT FOR DISCLOSURE OF CLIENT/ PATIENT
RECORDS OR COMMUNICATION: PRIMARY CARE
PHYSICIAN**

I hereby authorize _____ to disclose information and/or receive information to the extent or nature indicated to/from Primary Care Physician _____
PCP Address: _____ for the purpose of _____.

The information to be disclosed shall be limited to that information necessary to fulfill the above-stated purpose and may include the following items (**unless crossed out by me**):

- Psychological & neuropsychological test results
- Raw data from psychological and neuropsychological tests
- Clinical notes, including correspondence and billing/insurance information
- Psychological and neuropsychological reports
- Other: _____

regarding: (Client/Patient Name) _____ DOB: _____

I understand that in New Jersey the communications between patients and psychologists are privileged and confidential and, in most instances, may only be released with my written consent. I also understand that I may revoke this consent at any time except to the extent action has been taken in reliance thereon. This consent is effective immediately and will expire after _____ days from the date of signature. However I also understand that I may revoke my consent before _____ days elapses by writing to you and withdrawing my consent. This consent is for the above stated purposes only and specifically does not authorize the release of documents or information therein to any other party except as required in the filing of court documents in connection with the aforesaid purpose. I understand that treatment, payment, enrollment, or eligibility for benefits in an insurance plan cannot be a condition of authorization of psychotherapy notes (not progress notes as defined by HIPAA, federal law). I understand that once information is released, there is potential for that information to be re-disclosed and no longer protected by HIPAA. A photocopy of this consent form is as good as the original.

I hereby release _____, his/her personnel, officers, directors, and professional health care providers from any and all legal responsibility or liability resulting from the release of the above information to the extent indicated and authorized herein.

Signed: _____
Parent, Sole Legal Guardian if Client/Patient is under 18 years of age

Signed: _____
Other Parent if joint custody of Minor

Date: _____