545 Island Road, Suite 2B
Ramsey, NJ 07446
Ph 201-995-1004
Fax 201-345-7121

Authorization for Release of Information

Client Name: ___________________________
Date of Birth: ___________________________

I give my authorization for _____________________________ to discuss and share all relevant
(clinician name)
clinical information (verbal or written) regarding ________________________________ with the
(client name)
following for the purpose of ____.

1) Name: ____
   Address: ____
   Phone Number: ____
   Fax Number: ____
2) Name: ____
   Address: ____
   Phone Number: ____
   Fax Number: ____
3) Name: ____
   Address: ____
   Phone Number: ____
   Fax Number: ____
4) Name: ____
   Address: ____
   Phone Number: ____
   Fax Number: ____

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: ___________________

I understand that in New Jersey the communications between clients and providers 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.

____ ___________________
Signature of parent/ guardian (if patient is under 18) Date

____ ___________________
Signature of patient (if over 18) Date