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Ramsey, NJ 07446  
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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:

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