Clinical Psychotherapy & Consultation, LLC
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AUTHORIZATION TO RELEASE/OBTAIN PROTECTED INFORMATION

*PATIENT NAME: _____

*DATE OF BIRTH: _____DATE(S) _____through_____

I hereby authorize Clinical Psychotherapy & Consultation LLC. to _____ release or _____ obtain information by telephone, mail, courier or facsimile (fax) transmittal to/from:

*PERSON OR ORGANIZATION: _____

*ADDRESS: _____

*CITY/STREET/ZIP: _____

*PHONE #: _____

*FOR THE PURPOSE OF: _____

*The following information is to be disclosed:

- ☐ Inpatient Discharge Summary
- ☐ Integrated Assessment
- ☐ History & Physical Examination
- ☐ Lab Tests/ X-rays
- ☐ Legal Documents
- ☐ Treatment Summary
- ☐ Assessment Summary
- ☐ All Psychological and/or Psychiatric records
- ☐ Telephone Contact
- ☐ Medication Profile Summary
- ☐ Complete Chart Copy
- ☐ Outpatient Discharge Summary
- ☐ Outpatient Psychiatric Summary
- ☐ Outpatient Clinical Assessment
- ☐ Letter to confirm Dates of Treatment
- ☐ Other_____

NOTICE TO PATIENT AND RECIPIENT OF RECORDS

This information has been disclosed to you from records protected by Federal Confidentiality rules (42 CFR Part 2) and New Jersey Public Law 303. This Release of Information demonstrates compliance with Health Insurance Portability and Accountability Act (HIPPA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgates thereunder. The Federal rules prohibit you from making any further disclosure of this pertains or as otherwise permitted by 42 CFR Part 2 and New Jersey Public Law 303. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I have been informed and understand that this authorization is subject to revocation by me at any time except to the extent that Clinical Psychotherapy & Consultation, LLC. has already taken action in reliance on it. If I do not revoke this authorization it will automatically expire one (1) year from the date of signature unless otherwise noted below. Once the requested protected health information is disclosed, the Privacy Regulations may no longer protect it if the PHI's recipient discloses it. Further, I understand that despite all care taken, information is occasionally received by a party not intended to be the recipient. I hereby release Clinical Psychotherapy & Consultation, LLC from all liability should this information be received by someone other than the above-intended recipient. I further understand that the information disclosed may include psychiatric, drug/alcohol abuse and/or HIV data.
This authorization will remain in effect from the date of this authorization until it expires in 1 year.

*_____
PATIENT'S SIGNATURE DATE

*_____
THERAPIST/WITNESS SIGNATURE DATE

*_____
PARENT OR GURADIAN DATE

*_____
PARENT OR GUARDIAN DATE