Princeton Family Institute

166 Bunn Drive, Suite 105 • NJ 08540-2849 • Tel 609.921.2551 Fax 609.921.2298 • www.princetonfamily.com

AUTHORIZATION/CONSENT FOR DISCLOSURE OF CLIENT/PATIENT RECORDS OR COMMUNICATION

I hereby authorize_____

of **Princeton Family Institute** to disclose information and/or receive information to the extent or nature indicated to/from Recipient Name/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**)

Drug and/or alcohol abuse information
History and psychological examinations
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: (PATIENT NAME)_____whose date of birth is_____ and whose social security number is_____

[ ] If checked this authorizes your testimony at deposition or trial regarding the above.

I understand that in the State of___the communications between patients and mental health practitioners 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, l 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 filling 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 (nor progress notes as defined by HIPM, federal law). I understand that once information is released, there is potential for that information to be redisclosed and no longer protected by HIPPA. A photocopy/FAX of this consent form is as good as the original.

I hereby release _____, and all employees, personnel, officers, directors, and professional health care providers of **Princeton Family Institute** from any and all legal responsibility or liability resulting from the release of the above information to the extent indicated and authorized herein.

Signed:_____

Date_____

Client/Patient if age 14 or over

Signed: _____

Parent or Legal Guardian if Client/Patient is under 18 years of age

Signed: _____

Other Parent if joint custody of Minor