NEW JERSEY'S NEW WAYS FOR FAMILIES, LLC

www.newwaysnj.com

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AUTHORIZATION FORM

This form when completed and signed by you, authorizes me to release protected information to the person you designate.

I authorize my psychologist and/or administrative staff to release:

(Provide description of the information that you want disclosed. Your description should be as specific and detailed as possible. The information may include for example; Behavioral Declarations, appointment and payment information and basic facts of the case. If all of these examples are agreeable, simply circle them)

_____

This information should only be released to:
(name, address and phone of person to whom the information is to be released)

_____

I am requesting my psychologist to release this information for the following reasons:
(If you do not desire to state a specific purpose, please circle the following: "at the request of the individual")

_____

This authorization shall remain in effect until (fill in expiration date) or until (fill in an event that relates to the individual or the purpose of the use or disclosure).

_____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization.

_____ _____
Signature of Patient Date