CALM & SENSE THERAPY

Authorization for Release of Information

I, _____ (D.O.B._____) give my permission to:

_____
(Name and address of person/agency from whom records are to be obtained)

to: _____
(Name and address of agency receiving information.)

to release the following information for the purpose of:

_____

I understand that verbal or written information will be disclosed only for the purpose noted above, and that the information released will be limited to the following items:

____ Psychiatric evaluation
____ Intake records
____ Medication records
____ Psychosocial data
____ Psychological Assessment
____ Education/CST evaluation
____ Other (Please Explain)

____ Treatment progress
____ Discharge summary
____ Prognosis/Diagnosis
____ Substance Abuse assessment
____ Substance Abuse treatment
____ Legal status/reports

_____

This authorization shall remain in effect until _____.
(date or event upon which this authorization expires)

You have the right to revoke this authorization, in writing, at any time by sending a letter indicating your wishes. However, your revocation will not be effective to the extent that we have taken action in reliance on this authorization. If you do this, it will prevent any releases after the date it is received but cannot change the fact that some information may have been sent or shared before that date.

_____ _____
Signature of client or his or her personal representative Date

_____ _____
Printed name of client or personal representative Relationship to client

Witness Signature:_____

551 Park Ave.
Suite 7
Scotch Plains, NJ 07076

786 Mountain Blvd.
Suite 104
Watchung, NJ 07069

2204 Morris Avenue
Suite 308
Union, NJ 07083

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