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Authorization/Consent for Disclosure of Patient Records or Communication

I hereby authorize Debra Diaz, LCSW to disclose information and/or receive information to the extent or nature indicated to/from

Recipient Name_____

Address_____

Phone_____

for the purpose of: __ coordination of treatment __ collaboration __ other: _____.

Specific information to be released/obtained:__ mental health/psychotherapy treatment goals/progress/summary

__ diagnosis __ treatment dates/history __ reports/assessments __ other: _____.

The information to be disclosed shall be limited to that information necessary to fulfill the above-stated purpose

regarding: **Patient Name** _____ **Date of Birth** _____

Address_____

I understand that in New Jersey 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 one year from the date of the signature below. However I also understand that I may revoke my consent before one year elapses by writing to you and withdrawing my consent. This consent is for the above stated purpose 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 Debra Diaz, LCSW, its employees, 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.

PRINT PATIENT NAME	PATIENT SIGNATURE	DATE
IF PATIENT IS UNDER 18 YEARS OLD/ UNABLE TO GIVE CONSENT, PRINT NAME OF PARENT(S)/ SOLE LEGAL GUARDIAN	IF PATIENT IS UNDER 18 YEARS OLD/ UNABLE TO GIVE CONSENT, SIGNATURE OF PARENT(S)/ SOLE LEGAL GUARDIAN	DATE
IF JOINT CUSTODY OF MINOR, PRINT NAME OF OTHER/PARENT/ OTHER LEAGAL GUARDIAN	IF JOINT CUSTODY OF MINOR, SIGNATURE OF OTHER/PARENT/ OTHER LEAGAL GUARDIAN	DATE