

Comprehensive Counseling Center

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AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ hereby authorize _____
(patient/guardian name) (therapist name)

to disclose information from the records _____
(patient name)

to be disclosed to _____
(Health Care Facility/other treatment provider)

(contact person) (Telephone Number)

for the purpose of _____

Information to be disclosed is as follows _____

I may revoke this consent at anytime except to the extent that action has been taken in reliance on it. This release will automatically expire (6) six months from date signed.

Patient/Guardian Signature

Date

Witness

Date

This information has been disclosed from records whose confidentiality is protected by federal law (42CFR-Part 2), therefore prohibiting any further disclosures without specific written consent.