HADDONFIELD PSYCHMANAGEMENT, P.A.
Comprehensive Psychological Services

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AUTHORIZATION FOR RELEASE OF INFORMATION

REQUEST FROM:	RELEASE TO:
Name:____________________	Name: ____________________
Address:____________________	Address: ____________________
City, State, Zip____________________	City, State, Zip____________________
Telephone: ____________________	Telephone: ____________________

I hereby authorize the request of treatment records to be released by mail, courier, or facsimile transmittal for the below named patient. The following information is to be released solely for the following use:

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- This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFP Part 2) and New Jersey Public Law 303. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFP Part 2 and New Jersey Public Law 303. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
- I have been informed and understand that this authorization, except for action already taken, may be voided by me at any time. If I do not void this authorization, it will automatically expire 90-days from the date of signature. Further, I understand that despite all care taken, information is occasionally received by a party not intended to be the recipient. I hereby release Haddonfield PsychManagement, P.A. from all liability should this information be received by someone other than the above intended recipient.

Dated: ____________________

Print Patient Name: ____________________

Patient SS# ____________________

Patient DOB: ____________________

Patient Signature: ____________________
OR
(Parent/Legal Guardian)