aspire psychological LLC

201-639-4669 ● aspirespsychologicalgroup.com

Authorization To Release Records

Client's Name: _____ Date of Birth: _____

Legal Authorized Consenter: _____ Date of Release: _____
(Only if unable to act as legal consenter of self- advanced directive completed)

The legal authorized consenter hereby gives permission to:

Aspire Psychological LLC

To Obtain: _____ release: _____ the following information (please check those that apply)

___ Entire Record	___ Psychological tests	___ Diagnosis
___ Treatment plans	___ Laboratory tests	___ Service history
___ Summary of treatment/progress	___ Psychiatric evaluation	___ Behavioral reports
___ Psychiatric history	___ Admission record	___ School Records
___ Medication history	___ Social work assessment	___ Judicial information
___ Medical history	___ HIV/AIDS	___ Other

From/To:
Person's Name: _____
Organization: _____
Street Address: _____
City, State, Zip _____
Phone: _____ Fax: _____ Email: _____

This information may be given: ____ as needed ____ one time

Purpose This information may be used or disclosed in connection with mental health treatment, payment, or healthcare operations. If the purpose is other than as specified above, please specify:
_____

_____

Expiration of Release:
I understand that I have a right to inspect any materials to be disclosed subject to provision of NJAC 10:37-613 G3.4 respecting client access to records. I understand the nature of this authorization and I understand I may revoke this authorization in writing at any time. In the event of termination of services, I understand this authorization will expire four months from the date of termination. In consideration of this consent, I hereby release the above parties from any legal liability resulting from the release of this information.

_____
Client's Name- Print Date

_____
Signature of Client Date

_____
Signature of Person Authorized by Law to Give Consent (only if advanced directive completed) Date

Signature of Witness/Therapist Date