The Institute for Change
CONSENT TO RELEASE CONFIDENTIAL INFORMATION

460 Bloomfield Ave
Suite 211
Montclair, NJ 07042
(973) 734-0780

44 Elm Street
Second Floor
Morristown, NJ 07960
(973) 734-0780

Re: Name_____ D.O.B._____

To: _____

Name of Persons, Organization or Institute

Street _____City _____ State_____ Zip_____

I hereby authorize you to _____release to ____exchange with The Institute for Change information from my records or my child's records with the understanding that this information will be considered privileged and confidential.

I understand that the specific type of information to be disclosed includes and may not be limited to:

_____Length of time in treatment
_____Diagnosis, brief description of progress and prognosis
_____Treatment recommendations
_____Discharge or closing summary
_____Medical history
_____Copy of reports
_____Other _____

This information is needed for the following purposes:

_____Diagnostic and evaluation purposes
_____To provide on-going treatment
_____Other_____

I understand that I need not consent to the release of information in order to obtain treatment services. I choose to do so willingly and voluntarily for the purposes specified above. I understand that I may revoke this consent at any time by notifying my therapist in writing, except to the extent that action been taken in reliance on my consent. This consent will otherwise expire one year from the date indicated below.

_____ _____ _____
(Witness) (Signature) (Date)

If patient is 14 years or younger _____
(Parent Signature)