THE INSTITUTE FOR CHANGE

973-734-0780

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

Mailing Address: IFC, PO Box 289, Caldwell, NJ07006

Re: Name_____ D.O.B._____
Patient's Name

To: _____
Name of Persons or Organization

Street_____City_____State_____Zip_____

Below please indicate whether the information is to only be *released* to IFC or if IFC can also *share information* [exchange with] with the above-named entity:

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 is limited to:

_____Length of time in treatment
_____Diagnosis, description of progress and prognosis
_____Treatment recommendations
_____Discharge or closing summary
_____Medical history
_____Copy of reports
_____Behavioral Observations
_____Other_____

This information is needed for the following purposes:

_____Diagnostic and evaluation purposes
_____To Provide on-going treatment
_____Other_____

Name of therapist at IFC:_____

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.

_____ _____
Signature of Patient, or Parent/Guardian if Patient is a Minor Date