597 Springfield Ave.
Summit, NJ 07901
Telephone (908) 273-3133

CONSENT FOR DISCLOSURE OF PSYCHOLOGICAL RECORDS

I hereby authorize Dr. ______________________

of Cognitive Therapy & Consultation, LLC to release to:

____

____

____

for the purpose of: ____

____

the following information (to the extent indicated below) regarding:

PATIENT'S NAME: _____________________________

DATE OF BIRTH: ___________

The Federal Regulation/s (42 CFR Part 2) prohibits any further release of this information.

________ Psychological evaluation

_______ Progress Notes

_______ Final summary

________ Medication history including response

________ Other _____________________________

I understand I may revoke this consent at any time except to the extent that no action has been taken in reliance thereon. This consent will expire 1 year from the date of signature.

DATE: ________ PATIENT SIGNATURE: ___________________________

WITNESS: _____________

Or signature of Parent, Legal Guardian or Authorized party