COGNITIVE THERAPY & CONSULTATION, LLC

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