

Leadem Counseling & Consulting Services, P.C.
668 Commons Way
Toms River, NJ 08755

Request/Authorization to Release Confidential Records and Information

Client Name: _____ **Date:** ____/____/____
DOB: ____/____/____ **SS Number:** ____ - ____ - ____
Address: _____

Release of Information From:	Release of Information To:
<input type="checkbox"/> Leadem Counseling & Consulting Services, P.C. <input type="checkbox"/> _____ Individual/Organization	<input type="checkbox"/> Leadem Counseling & Consulting Services, P.C. <input type="checkbox"/> _____ Individual/Organization
Street Address City, State, Zip	Street Address City, State, Zip
Phone Fax	Phone Fax

Purpose of Release

Dates of service for records requested: Beginning: ____/____/____ **Thru:** ____/____/____

Specify Methods Information Can Be Relayed: Mail Email Phone Fax

- | | |
|---|---|
| <input type="checkbox"/> Discharge Planning | <input type="checkbox"/> Further Mental Health Evaluation, Treatment, or Care |
| <input type="checkbox"/> Treatment Planning | <input type="checkbox"/> Rehabilitation Program Development or Services |
| <input type="checkbox"/> Legal | <input type="checkbox"/> Other: _____ |

Information to be Released

- | | | |
|--|---|--|
| <input type="checkbox"/> Intake and Discharge Summaries | <input type="checkbox"/> Educational Records | <input type="checkbox"/> Mental Health Evaluations |
| <input type="checkbox"/> Developmental and/or Social History | <input type="checkbox"/> Substance Abuse Evaluation | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Medical History and Evaluation(s) | <input type="checkbox"/> Termination Summary | <input type="checkbox"/> Other: _____ |

Consent to Release Information

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within **90 days**, except to the extent that action based on this consent has already been taken.

- This authorization will expire 90-days from the date signed below unless another date or event is entered here:

- Drug and alcohol information contained in these records will be released under this consent unless indicated here:

Signature of Patient/Legal Representative

_____ Signature of Patient/Legal Representative	_____ Relationship to Patient	_____ Date
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- Copy for patient or parent/guardian Copy for source of records Copy for recipient of records