Child and Family Counseling Center, LLC
Larry Fisch, MSW, LCSW
320 Raritan Ave., Suite 307A
Highland Park, NJ 08904

AUTHORIZATION FOR RELEASE / EXCHANGE OF PROTECTED HEALTH INFORMATION

_____ _____
Patient's Name Date of Birth

I hereby authorize **Child and Family Counseling Center** located at **320 Raritan Ave., Suite 307A, Highland Park, NJ 08904**

to disclose to:
or obtain from: (circle one)
_____
_____
_____
the following specific information:
_____Discharge summary
_____Treatment Plans
_____Alcohol/Drug Abuse Diagnosis and/or information
_____HIV/AIDS Diagnosis or information
_____Other, please specify _____

The purpose of disclosure: _____

Approximate dates of treatment: _____

_____ _____
Signature of Patient Date signed

_____ _____
Signature of Parent, Guardian, or Authorized Representative in lieu of Patient Date signed

_____ _____
Signature of Witness Date signed

NOTICE FOR DRUG AND ALCOHOL ABUSE RECORDS

This information has been disclosed to you from Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any drug or alcohol patient.

Duration of Release: This completed release/exchange of information form is good for four months unless another length of time is specified on the form or consent is revoked in writing by the patient or appropriate representative.