GOLD PSYCHOLOGICAL SERVICES
Psychological, Forensic, Educational and Therapeutic Services

701 E Brookside Lane
Hillsborough, NJ 08844

Phone: (973) 615-7759
Email: drgoldstein8@gmail.com

Web: www.goldpsychological.com

REQUEST/AUTHORIZATION TO RELEASE CONFIDENTIAL RECORDS AND INFORMATION

I hereby authorize:

Person or facility:
____

Address: _____________________________ Phone: ______________________

____

to exchange information from records about ________________________, born on

____________,

with:

Person or facility:
____

Address: _____________________________ Phone: ______________________

____

for the following purpose(s):

□ Further mental health evaluation, treatment, or care

□ Treatment planning

□ Other: ____

These records concern the time between _____________________ and

_____________________.

The information to be disclosed is marked by an X in the boxes below:

□ Medical history and evaluation (s)

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□ Mental health evaluations
□ Developmental and/or social history

□ Educational records

□ Progress notes, and treatment or closing summary

□ Other: ____

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, except to the extent that action based on this consent has already been taken. This consent will expire automatically after one year from the date on which it is signed, or upon fulfillment of the purposes stated above.

______________________	______________________	____________
Signature of client or parent	Printed name	Date