The North Jersey Center for Cognitive Behavioral Therapy
239 Madison Avenue
Wyckoff, NJ 07481
(201) 669-1369

Authorization for Release or Exchange of Confidential Information

I hereby authorize the following provider to release or exchange confidential information pertaining to my medical, psychological, and/or psychiatric history. This information is being requested for the purpose of completing patient assessment and treatment.

Provider Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____

I understand that I may revoke this consent at any time by informing the above parties in writing. However, my revocation will not be effective to the extent that action has been taken in reliance on the authorization.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPPA Privacy Rule.

_____ _____
Name of Patient Signature of Patient

_____ _____
Signature of Parent/Guardian Date

_____ _____
Witness Date