Consent for Release of Information

Rambler Mental Health
1001 Fischer Blvd. Suite 3-133
Toms River, NJ 08753
Phone: 732-930-2161
Fax: 848-244-9343

I _____ hereby authorize release of treatment records to & from:

Name/Agency: _____

Address: _____

_____

This release pertains to services rendered to:

Name: _____ D.O.B. _____

Address: _____

_____

This signed release authorizes release of the items checked and initialed below:

☐ ____ Intake Information
☐ ____ Mental Health Information/Evaluations
☐ ____ Treatment Performance Records
☐ ____ Letters written on behalf of patient
☐ ____ Progress Notes
☐ ____ Exchange of Information (verbal and/or written)
☐ ____ Other _____

The requested information is intended for the recipient identified on this sheet only and privacy laws prohibit further disclosure. By way of illustration and not by way of exhaustion, these laws include those listed under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. It is the policy of this office to not release third party information or any records not originally produced by this office. Such information must be obtained by writing to the other entity directly.

A reproduction of this authorization form shall be considered as the original. I understand that by law I do not have to release this information, but I choose to do so voluntary. I further understand that I may cancel this authorization by specifying such, in writing, at any time. I understand that written withdrawal of this authorization prevents any future release of information but does not protect against information that was sent prior to receipt of withdrawal of release. If I do not exercise my right to withdrawal this release it shall automatically expire in 24 months from the date of authorization below.

_____ _____
Patient Signature Date of Authorization

_____ _____
Guardian/Parent/Authorized Representative Witness/Therapist Signature