



**Child and Family**  
— COUNSELING CENTER, LLC —

**Larry Fisch, MSW LCSW**

**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.