Find Your Balance Counseling Group, LLC
240 US Highway 206, Unit 20, Flanders, NJ 07836
findyourbalancecounseling.com

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, D.O.B._____do hereby consent to and authorize _____to disclose to information from my health care record relating to my:

____ Identity
____ Diagnosis
____ Prognosis
____ Treatment
____ Special Tests Performed
____ Other (Specify)

During the following period/s of time:

I also understand that this consent is revocable. Unless action has already been taken and that this consent will remain in force in order to effectuate the purposes for which it is given until (_____), after which it will be void.

Dated this_____ day of _____, 20____.

I also understand that in accordance with New Jersey state regulations, as of October 1, 2018 it is required by law that if eminent danger is determined, it is this clinician's legal "Duty to Warn" which includes disclosure of this information to the local police. However this does not always mandate a call to DCP&P or breaking confidentiality regarding client and therapist privileged information.

_____
Signature of Patient

_____
Parent/Guardian

_____
WITNESS