Children's Center
for Psychological Assessment & Development

(856) 745-6291
childrenscenter@childrenscenterphilly.com
www.childrenscenterphilly.com

RELEASE OF INFORMATION

Name of Client: _____

Date of Birth: _____

I understand that New Jersey and Pennsylvania state law requires each legal guardian and/or client's consent for the release of confidential information related to mental health, educational history, or medical records. With this understanding, I hereby waive any right to confidentiality arising under New Jersey and Pennsylvania state law and authorize the release of records of information, but only the extent specified below.

I authorize _____ to release and/or receive the following information concerning myself or my child:

_____ Diagnostic Evaluation Results

_____ Educational/school Records

_____ Progress Notes

_____ Treatment Plan

_____ Treatment Summary

_____ Discharge Reports

_____ Medical Records

_____ Other _____

The above information is only to be released to, and/or from, the following party:

_____
Name and/or Agency

_____
Address, City, State, Zip Code

This information is to be used for the purpose of _____.

This authorization shall remain in effect for 180 days at which time it shall expire and no further release of information shall be made under its terms. I understand that I can revoke this authorization at any time by giving written notice to the parties named above. I also understand that I have the right to examine and copy the information disclosed.

I hereby release the parties named above from any liabilities for release of this information.

_____
Signature of Legal Guardian

_____
Date