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*American Board of Professional Neuropsychology  
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## CONSENT FOR DISCLOSURE OF CLIENT/PATIENT RECORDS OR COMMUNICATION

I hereby authorize Dr. \_\_\_\_\_ to disclose information and/or receive information to the extent or nature indicated to/from **Recipient Name/ Address:** \_\_\_\_\_ for the purpose of \_\_\_\_\_.

The information to be disclosed shall be limited to that information necessary to fulfill the above-stated purpose and may include the following items (**unless crossed out by me**)

- Drug and/or alcohol abuse information
- Information regarding Immunodeficiency virus (HIV) including laboratory test results
- Diagnosis of AIDS or ARC, if applicable
- History and physical examinations
- Psychological & neuropsychological test results
- Raw data from psychological and neuropsychological tests
- Clinical notes, including correspondence and billing/insurance information
- Psychological and neuropsychological reports
- Other: \_\_\_\_\_

regarding: **(PatientName)** \_\_\_\_\_

whose date of birth is \_\_\_\_\_ and whose social security number is \_\_\_\_\_.

[    ] If checked this authorizes your testimony at deposition or trial regarding the above.

I understand that in New Jersey the communications between patients and psychologists are privileged and confidential and, in most instances, may only be released with my written consent. I also understand that I may revoke this consent at any time except to the extent action has been taken in reliance thereon. This consent is effective immediately and will expire after \_\_\_\_\_ days from the date of signature. However I also understand that I may revoke my consent before \_\_\_\_\_ days elapses by writing to you and withdrawing my consent. This consent is for the above stated purposes only and specifically does not authorize the release of documents or information therein to any other party except as required in the filing of court documents in connection with the aforesaid purpose. I understand that treatment, payment, enrollment, or eligibility for benefits in an insurance plan cannot be a condition of authorization of psychotherapy notes (not progress notes as defined by HIPAA, federal law). I understand that once information is released, there is potential for that information to be redisclosed and no longer protected by HIPAA. A photocopy of this consent form is as good as the original.

I hereby release Dr. \_\_\_\_\_, his/her employees, personnel, officers, directors, and professional health care providers from any and all legal responsibility or liability resulting from the release of the above information to the extent indicated and authorized herein.

Signed: \_\_\_\_\_  
Client/Patient if 13 years or older

Signed: \_\_\_\_\_  
Parent, Legal Guardian if Patient is under 18 years of age

Signed: \_\_\_\_\_  
Other Parent/Legal Guardian

Date: \_\_\_\_\_