Diane Haley, LCSW, OSW-C

Lauren Myler LCSW, OSW-C

Lisa Picciuti, LCSW, OSW-C, CTTS

261 James St, Suite 1C

Morristown, NJ 07960

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ whose date of birth is \_\_\_\_\_\_\_\_\_\_\_authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, LCSW, OSW-C to disclose to and/or obtain from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ the following information: assessment, diagnosis, psychosocial, psychological, or psychiatric evaluation, treatment plan or summary, treatment update, nursing or medical information, toxicology reports, educational information, discharge/transfer summary, continuing care plan, progress in treatment and/or medication management information.

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment, and when appropriate, coordinate treatment services. If other purpose, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization. Unless sooner revoked, this consent expires on the following date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I further understand that my treatment is not contingent upon whether I give authorization for the requested disclosure. Unless specifically requested in writing that the disclosure be made in a certain format, information will be disclosed as permitted in any manner deemed appropriate and consistent with applicable law, including, but not limited to verbally, in paper format or electronically. Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure.

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Signature of Patient Date

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Signature of Staff Witness Date