Counseling Center at Hamilton, LLC.

Release of Information

This will authorize:

Counseling Center at Hamilton, LLC.
277 Soden Drive
Hamilton, NJ 08620
Office 609-890-9998

To release/exchange to/with:

The information to be discussed will be used for professional purposes only and consists of:

Intake
Treatment Plans
Medical History
Psychiatric Evaluation
School Performance
Drug/Alcohol Assessment
Psychological Tests
Diagnosis
Medication History
Laboratory Tests
Student Evaluation Report
Service History
Final Summary
Psychiatric History
School Attendance
Other:

The following information may assist in locating the requested records:

Client: Date of Birth:

Address:

I hereby grant permission voluntarily for the above parties to release/exchange information relevant to my treatment. I understand that specific information to be released may include reference to alcohol/drug abuse, AIDS/HIV infection, and/or psychiatric conditions and the treatment thereof. If this information is documented in my medical or school records, I agree to the release of it. This information will be used only for professional purposes and its confidential nature will be respected. I understand that I may cancel this authorization for release of information at any time unless the information has already been sent. I understand that I have the right to inspect any materials disclosed subject to the provisions of NJAC 10:37-6:19G3:4, respecting client access to records.

Client Signature and date:

Parent/Guardian Signature and date:

Therapist Signature and date: