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Morganville, NJ 07751
732-617-6210 (Phone)
732-617-6211 (Fax)
www.britefuturescounseling.com

Authorization for Release or Disclosure of Information

Please carefully read the following information before signing this form. If you do not understand the nature of the information to be released, please ask. This form should be completely filled out before you sign it.

- I understand that the release of information is in my best interest and/or my child's best interest and is not a required condition of treatment.
- I understand that the release of information is limited to the party (s) named below and that it will not be passed on to anyone else or used for any other purpose other than that specified below.
- I understand that I may cancel authorization at any time by signing and dating the original of this authorization where indicated. I understand that cancellation does not affect prior action taken under this authorization.
- I understand that a photocopy of this authorization is as authentic as the originally signed authorization for release of information.

I, _____ authorize Brite Futures Counseling, LLC to release or disclose
(Print Name)
Information to:

Full Name: _____

Phone: _____

Email: _____

Address: _____

I hereby authorize Brite Futures Counseling, LLC to disclose the following information: **(check those which relate)**

___Intake and Discharge Summaries	___Evaluations	___Educational Notes
___Medical History and Evaluations	___Therapy Notes	___Other _____
___Developmental and/or Social History	___Phone Consultation	___**All Those Listed**

Authorization for Release or Disclosure of Information (Cont.)

For the following identified purpose: _____
(describe each purpose of the requested use or disclosure)

This authorization will expire:

☐ At the end of 90 days ☐ At termination of treatment ☐ Till specific date:_____

I understand that I may receive a copy of this authorization, upon request.

Relationship to Client: ☐ Self ☐ Parent

Client's Name (Print):_____

Parent/Guardian's Name (Print):_____

Signature: _____ Date: _____
(Self/Parent/Guardian)

For Client/Minor Ages 14 – 17 (ONLY)

Please carefully read the following information before signing this form. If you do not understand the nature of the information to be released, please ask.

- I understand that the release of information is in my best interest and is not a required condition of treatment.
- I understand that the release of information is limited to the party (s) named above and that it will not be passed on to anyone else or used for any other purpose other than that specified above.
- I understand that I may cancel authorization at any time by signing and dating the original of this authorization where indicated. I understand that cancellation does not affect prior action taken under this authorization.
- I understand that a photocopy of this authorization is as authentic as the originally signed authorization for release of information.

Client's/Minor's Name (Print):_____

Signature: _____ Date: _____
(Client/Minor)