100 Campus Drive, Suite 101
Morganville, NJ 07726
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 in 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 original signed authorization for release of information.

I, _____authorize Brite Futures Counseling ,LLC to release or disclose
(Print Name)

information to: 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

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

To be released for : ____Brite Futures Counseling, LLC
(check)

This authorization will expire

___At the end of 90 day ___At termination of treatment __Or _____

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

Print Name _____

Relationship to Client: Self _____ Parent_____

Client's Name_____

Signature _____ Date: _____