APS Advanced Psychological Specialists, LLC

NANCY JUST, PH.D., ABPP
DIPLOMATE IN CLINICAL PSYCHOLOGY
AMERICAN BOARD OF PROFESSIONAL PSYCHOLOGY
LICENSE 03382

AUTHORIZATION/CONSENT TO DISCLOSE AND RECEIVE CLIENT RECORDS OR COMMUNICATION

I hereby authorize Advanced Psychological Specialists 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:

(Client Name)_____ whose date of birth is _____.

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

I understand that in the State of NJ the communications between clients and mental health practitioners 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. I also understand that I may revoke my consent before 7 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/FAX of this consent form is as good as the original.

I hereby release Advanced Psychological Specialists and related personnel 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/Client if age 14 or over

Signed:_____
Parent, Sole Legal Guardian if Client/Client is under 18 years of age

Signed:_____
Other Parent if joint custody of Minor

Date: _____

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