

Spring Behavioral Health of New Jersey  
**Authorization for Release of Confidential Medical Information**

Rev 11/2017

I, \_\_\_\_\_ hereby authorize Spring Behavioral Health of NJ to:  
Patient Name (Print)

**RELEASE Medical Information TO:**

Facility/Provider Name: \_\_\_\_\_

Address/Phone/Fax: \_\_\_\_\_

Facility/Provider Name: \_\_\_\_\_

Address/Phone/Fax: \_\_\_\_\_

the following information (please check all that apply):

Psychotherapy Notes     Psychiatry Notes     Assessment/Testing Notes     Other \_\_\_\_\_

\*\*\*Please provide specific dates and information that you are requesting\*\*\*

Purpose of Disclosure (Please select one only):

Transfer of care with another provider or facility     Personal Copy \*\*there is a charge if requesting for self\*\*

Other \_\_\_\_\_

**OBTAIN Medical Information FROM:**

Facility/Provider Name: \_\_\_\_\_

Address/Phone/Fax: \_\_\_\_\_

the following information \_\_\_\_\_

Purpose of Disclosure (Please select one only):

Treatment Planning     Other \_\_\_\_\_

**ALLOW VERBAL COORDINATION OF CARE WITH:**

Facility/Provider Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Purpose of Disclosure (Please select one only):

Coordination of Care     Other \_\_\_\_\_

This authorization will remain in effect for one (1) year from date of signature below unless otherwise indicated below:

**Authorization:** I am aware that this information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by the Privacy Rule. I understand that I have the right to revoke this authorization by writing, at any time, and sending such written notification to our office address. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has legal right to contest a claim. I understand that Spring Behavioral Health of New Jersey generally may not condition services upon my signing as authorization unless the services are provided to me for the purpose of creating protected health information for disclosure to a third party. **We DO NOT release any confidential medical information which will not be used for treatment.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Parent/Legal Guardian Name (Print)

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Relationship to Patient    Date

\_\_\_\_\_  
Parent/Legal Guardian Name (Print)

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Relationship to Patient    Date

**\*\* If there is a court order awarding joint legal custody, both parental signatures are required \*\***