Behavioral Care Center of New Jersey, LLC
205 Ridgedale Avenue, Suite 101
Florham Park, NJ 07932
Phone: (973) 660-0700

RELEASE OF INFORMATION

I, _________________________, the legal guardian of _____________________________ give permission for therapist, ___________________, to receive and share the following information.

- All written reports including child study team, psychiatric, neurological, psychological, psychosocial
- Individualized Education Program
- Verbal reports
- Medical reports
- Other: ____

This information will be received from/shared with the following:

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This authorization will expire on: ____________________

I understand that I may refuse to sign this form and that I may revoke this authorization any time by informing the psychologist noted above in writing. If I do revoke authorization the revocation will not have any effect on actions the therapist has already taken in reliance on this authorization.

Signature:________________________________ Date: ________________

Clinician Name____________________________ Date: ________________