



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

RELEASE OF INFORMATION

I, \_\_\_\_\_, 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:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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 \_\_\_\_\_ in writing. If I do revoke authorization the revocation will not have any effect on actions \_\_\_\_\_ has already taken in reliance on this authorization.

Client Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Clinician Signature: \_\_\_\_\_

Date: \_\_\_\_\_