**Institute for Practical Life (IFP)**

Psychotherapy, Evaluations, Coaching and Wellness Programs

**Jusleine Expressions, LLC**

www.practicallifepsychotherapy.org

**Practice Location**:

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**Mailing address:**

P.O.Box 23

Edison,NJ 08818

Phone:(732)610-5119

Fax:(908)275-8073

**Authorization to Release and Obtain Information**

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

**Patient’s Name:**

**D.O.B.**

I, , hereby authorize the release to obtain from

and exchange with information specified below:

* COMPLETE RECORD
* Assessment
* Diagnosis
* Treatment Plan
* Summary of Treatment
* Response to treatment
* Social or Family History
* Prognosis
* Medication Management
* Transition Summary
* Progress Notes
* Recommendations
* Educational Evaluation
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To: Release to, or request, with the purpose of coordination of care or ongoing evaluation from:

Name:

Address:

Phone:

Fax number:

I understand that this directive is subject to revocation at any time upon my written request. Otherwise this consent will expire upon termination of services.

I herewith release and hold harmless.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Institute for Practical Life (732-610-5119) Service Provider.

Parent Signature and Date:

Client Signature and Date:

Witness/Clinician Signature and Date: