

Marisa Campanella-Harris, LPC LLC
NJ License: 37PC00620300
Authorization for Release of Information

Name of patient: _____

Date of Birth: ____/____/____

Name of parent/guardian if patient is a minor child _____

The above named individual hereby authorizes Mrs. Campanella-Harris, LPC to communicate with the individual and/or institution listed below:

Name of provider: _____

Contact address: _____

Contact telephone: _____

Contact fax: _____

Purpose of disclosure:

School-related

Employment-related

Legal

Coordination of Care with Professional Provider

Other (describe):

I understand this grants permission to the individual named to both obtain and/or release verbal information and/or written records, which may be relevant to the current evaluation of the patient(s) or their families. The released information may include information regarding the diagnosis and treatment of any mental health or substance abuse problem including psychotherapy notes or any educational records and information. I understand that this consent may be revoked in writing by me at any time by giving such notice to both the above-named and the recipient of the information named in this authorization. However, such revocation will not be effective to the extent that Marisa Campanella-Harris, LPC and the professionals or institutions named above have already taken action in reliance of this authorization. A photocopy or facsimile of this release shall be valid as the original.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if applicable): _____