I hereby release Dr._____, his/her employees, personnel, officers, directors and professional health care providers from any and all legal responsibility or liability resulting from the release of the above information to the extent indicated and authorized herein.
Signed: _____ Client/Patient if age 14 or over

Signed: _____ Parent, Sole Legal Guardian if Client/Patient is under 18 years of age

Signed: _____ Other Parent if joint custody of Minor

Date: _____

AUTHORIZATION/CONSENT FOR DISCLOSURE
OF CLIENT/PATIENT RECORDS OR COMMUNICATION

Dr. Gregory G. Lomuti
The Office Court of Ramsey,
1000 C Lake Street, Suite #6,
Ramsey, NJ 07446

I hereby authorize Dr,. Gregory G. Lomuti/_____ to disclose information and/or receive information to the extent or nature indicated to/from to **Recipient Name/Address:**
_____for the purpose of _____. The information to be disclosed shall be limited to that information necessary to fulfill the above-stated purpose and may include the following items **(unless crossed out by me)**
Drug and/or alcohol abuse information
Information regarding Immunodeficiency virus (HIV) including laboratory test results Diagnosis of AIDS or ARC, if applicable
History and physical examinations
Psychological & neuropsychological test results
Raw data from psychological and neuropsychological test
Clinical notes, including correspondence and billing/insurance information
Psychological and neuropsychological reports
Other: _____
regarding: (Patient Name)_____ whose date of birth is _____ and whose social security number is _____.
[ ] If checked this authorizes your testimony at deposition or trial regarding the above.

I understand that in New Jersey the communications between patients and mental health practitioners are privileged and confidential and, in most instances, may only be released with my written consent. I also understand that I may revoke this consent at any time except to the extent action has been taken in reliance thereon. This consent is effective immediately and will expire after _____days from the date of signature. However, I also understand that I may revoke my consent before _____days elapses by writing to you and withdrawing my consent. This consent is for the above stated purposes only and specifically does not authorize the release of documents or information therein to any other party except as required in the filing of court documents in connections with aforesaid purpose. I understand that treatment, payment, enrollment, or eligibility for benefits in an insurance plan cannot be a condition of authorization of psychotherapy notes (not progress notes as defined by HIPAA, federal law). I understand that once information is release, there is potential for that information to be redisclosed and no longer protected by HIPAA. A photocopy of this consent form is as good as the original.