Authorization to Release / Obtain Healthcare Information

Patient's Name: ________________________________ D.O.B. ________________

I request and authorize The Center for CBT of NJ to

Release/Obtain

My healthcare information To/From:

Name: ____

Relationship: ____

Address: ____

Phone number: ____

Please select one:

☐ Authorization is limited to the following information:

____

☐ All information

Patient/ Guardian Signature: ___________________ Date: ___________

Witness Signature: __________________________ Date: ___________

Expiration of Authorization (if applicable) ________________