

Marianne Grace Dunn, Ph.D.
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Woodcliff Lake, New Jersey 07677
NJ License # 5656 NY License # 019544

Authorization to Release/Exchange Information

I _____ hereby authorize Dr. Marianne Dunn to:

_____ release information to: _____ obtain information from:

Name: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Phone number: _____
Fax number: _____

For the purpose of (e.g., treatment planning, continuing treatment, determination of benefits, etc.)

Specific Information that will be released (e.g., entire record, treatment summary):

Expiration Date of Release*: _____

*Unless a date is specified, this authorization will remain in effect from one year from the date below.

Client Information:

Name (please print): _____ Phone number: _____
Date of Birth: _____
Social Security number: _____

Your relationship to the client: _____ Self _____ Parent/legal guardian _____ Other: _____

If you are a legal guardian or representative appointed by court, please attach a copy of the authorization to receive this protected health information.

I understand that this authorization is voluntary, and I have had an opportunity to discuss any consequences and implications arising from releasing protected health information. I understand that if any records or information is released to a non-health care provider or insurer, federal and state privacy laws and regulations may not protect their confidentiality. I understand that I may revoke this consent at anytime in writing by giving notice to Dr. Marianne Dunn and the recipient named above. I hereby release Dr. Marianne Dunn from any legal liability resulting from exchanging this information.

Signatures

Client signature: _____ Date: _____
Parent/guardian signature (if applicable) _____ Date: _____
Witness signature: _____ Date: _____