Marianne Grace Dunn, Ph.D.
645 Westwood Ave Suite 203 River Vale, NJ 07675
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:________