PARTNERS FOR HEALING AND CHANGEWORK
520 STOKES RD. SUITE C-4
MEDFORD, NJ 08055
609-714-0222

AUTHORIZATION FOR RELEASE/OBTAIN OF INFORMATION

I,_____, authorize Partners For Healing and

Changework to

[ ]obtain [ ] exchange with [ ] release

information from/to _____

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for the purpose of treatment planning and continuity of care. This information shall include:

[ ] Intake/assessment [ ]treatment summary

[ ] treatment progress [ ] School assessments

[ ] medical history [ ] medication [ ] other_____

Please initial here if authorization is acceptable via phone contact:[ ]

This authorization shall be in effect for the period of one year and may be revoked in writing to the above address. Revoked authorizations do not cover any information already released or obtained prior to the termination of authorization.

Signed_____ Date_____