MILLHILL CHILD & FAMILY DEVELOPMENT
Millhill Outpatient Clinic
Records Release Authorization

(Revised January 2015)

Client's Name: _ _____ Date of Birth: _____

Legal Authorized Consenter: _____ Date of Release: _____

The legal authorized consenter hereby gives permission to

Millhill Outpatient Clinic Child/Adolescent Outpatient Clinic
101 Oakland Street
Trenton, NJ 08618

To Obtain: _____ release: _____ the following information (please check those that apply)

___ medical history	___ laboratory tests	___ Service History
___ treatment plans	___ psychiatric evaluation	___ IEP/504 Plan
___ summary of treatment/progress	___ admission record	___ Behavioral reports
___ psychiatric history	___ social work assessment	___ Academic progress reports
___ medication history	___ student evaluation/records	___ Client history
___ attendance and cooperation	___ HIV/AIDS	___ Judicial information
___ psychological tests	___ Diagnosis	___ Other

From/To:

Person's Name: _____

Organization: _____

Street Address: _____

City, State, Zip _____

Phone: _____ Fax: _____ Email: _____

The purpose or need for such disclosure is:

____ Case Management ____ Treatment Compliance _____ (other)

This information may be given: ____ as needed ____ one time

Expiration of Release

I understand that I have a right to inspect any materials to be disclosed subject to provision of NJAC 10:37-613 G3.4 respecting client access to records. I understand the nature of this authorization and I understand I may revoke this authorization at any time. I understand this release of information automatically expires one year from the date the authorization is signed. In the event of termination of services, I understand this authorization will expire four months from the date of termination.

Signature of Person Authorized by Law to Give Consent Date

Signature of Witness/Therapist Date