**Lucas S. Rockwood, Psy.D.**
NJ License #4510
1 Cattano Avenue
Morristown, NJ 07960
(201) 572-3017

# Authorization to Release Information

Patient Name_____ Date of Birth_____

I hereby give Lucas S. Rockwood, Psy.D., permission to obtain information from, release information to, and/or discuss my case and my protected information with the company, agency, or individuals listed below:_____
_____
_____

This authorization shall remain in effect until (fill in expiration date) or until (fill in an event that relates to the individual or the purpose of the use of disclosure): _____
_____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have already taken action in reliance on the authorization.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPPA Privacy Rule.

_____
Patient Name (Print)

_____ _____
Signature of Patient Date

_____
Parent/Guardian (Print)

_____ _____
Signature of Parent/Guardian Date