

A Bright Tomorrow, LLC

990 Cedar Bridge Avenue, B7-104

Phone: 848-226-3280

Brick, NJ 08723

**AUTHORIZATION/CONSENT FOR DISCLOSURE OF CLIENT/PATIENT RECORDS
OR COMMUNICATION**

I hereby authorize *A Bright Tomorrow, LLC* to disclose information and/or receive information from recipient name and address:

For the purpose of _____

The information to be disclosed shall be limited to that information necessary to the fullest above stated purpose and may include the following items, unless checked off by recipient.

- History and physical examinations
- Psychological and Psychiatric test results
- Clinical notes
- Educational Information
- Other: _____

Regarding: (Client Name) _____ whose date of birth is _____.

I understand that I may revoke this authorization in writing submitted at any time, except to the extent that action has been taken in reliance upon this authorization, this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, or other law provides the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one (1) year from the date of my signature unless I have specified a different expiration date or event.

Enter date or event if different than 1 year after date shown above

I understand that *A Bright Tomorrow, LLC* will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party. I understand that information disclosed by this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule (45 CFR Part 164).

_____ Date _____

Signature of Client or Personal Representative

Printed Name of Client or Personal Representative

Relationship of Personal Representative Authority