

Jodi Rubin, ACSW, LCSW, CEDS
760 Route 46 West #1006, Parsippany, New Jersey 07054
Emergency Consent Form

CONSENT TO RELEASE INFORMATION PROTECTED BY BOTH STATE AND FEDERAL LAW

I, _____
(NAME OF PATIENT) (ADDRESS OF PATIENT)

HEREBY AUTHORIZE AND GIVE MY CONSENT TO _____ **Jodi Rubin** _____

TO OBTAIN AND RELEASE ANY NECESSARY INFORMATION IN THE CASE OF AN EMERGENCY

TO/FROM _____
(NAME OF PERSON TO WHICH DISCLOSURE WILL BE MADE)

(ADDRESS & PHONE NUMBERS OF PERSON TO WHICH DISCLOSURE WILL BE MADE)

_____ **for the duration of treatment** _____
(SPECIFIC DATE, EVENT OR CONDITION)

****THIS CONSENT IS SUBJECT TO REVOCATION AT ANY TIME EXCEPT TO THE EXTENT THAT THE PERSON WHO IS TO MAKE THE DISCLOSURE HAS ALREADY TAKEN ACTION IN RELIANCE UPON IT. IF NOT PREVIOUSLY REVOKED, THIS CONSENT WILL TERMINATE UPON ABOVE SPECIFIED DATE, EVENT OR CONDITION.***

DATE (ON WHICH THIS CONSENT IS SIGNED)

SIGNATURE OF PATIENT

SIGNATURE OF PATIENT'S PARENT OR GUARDIAN (WHERE REQUIRED)

SIGNATURE OF WITNESS

I UNDERSTAND THAT I AM NOT REQUIRED TO GIVE THIS CONSENT AND THAT I CAN REFUSE WITHOUT ANY PREJUDICE TO MY FUTURE TREATMENT.