Jodi Rubin, ACSW, LCSW, CEDS

10 West 15th Street, New York, New York 10011

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.