Princeton Psychotherapy
Karyn P. Bristol, MSW, LCSW

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RELEASE OF INFORMATION (Child/Adolescent)

I, _____, parent/guardian of_____,
(name of parent) (name of child)

whose Date of Birth is _____, authorize Karyn
(child's Date of Birth)

Bristol, LCSW, to disclose and/or obtain the following information from

_____:
(name of Person, Title of Person, or Organization)

_____Assessment	_____Nursing/Medical Information
_____Diagnosis	_____Toxicological Reports/Drug Screen
_____Psychosocial Evaluation	_____Educational Information
_____Psychiatric Evaluation	_____Discharge/Transfer Summary
_____Treatment Plan or Update	_____Progress in Treatment
_____Medication Management Info.	_____Demographic Information
_____Presence/Participation in Treatment	
_____Social History	_____School Reports
_____Other (please describe):	_____

The purpose of this disclosure of information is to improve assessment and treatment planning; share information relevant to treatment; and when appropriate, coordinate treatment services. If other purpose, please specify:_____

_____

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Karyn Bristol at the above address. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

I further understand that Karyn Bristol will not condition my treatment on whether I give authorization for the requested disclosure.

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for release, disclosure, and use of the protected health information described in this form with the people and/or organizations named in this form:

Signature:_____Date:_____

Unless sooner revoked, this consent expires one year from the date signed above.