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Release of information

I,(patient) _____, do hereby consent and authorize (provider)
_____ to disclose to/obtain from _____
information from my records related to identity, history, diagnosis, prognosis, or
treatment. The purpose for this disclosure is to _____. I
understand that the specific type of information to be disclosed is that from my
psychotherapy, psychiatric, medical, academic, work, or (other) _____
records. I understand that I have the right to review this material before signing this
consent. I also understand that this consent can be revoked at any time, except to the
extent that action has already been taken, and that this consent will remain in effect no
longer than the time reasonably necessary to accomplish the purposes for which it was
given.

Patient/Date

Witness/Date