CREATING HEALTHY ALTERNATIVES TOGETHERFORENSIC & CLINICAL ASSESSMENT SERVICES

PO BOX 577 4475 ROUTE 27 KINGSTON, NJ 08528-0577

OFFICE: (609) 333-1096

FAX: (609) 333-0761

Authorization for the Mutual Release and Exchange of Confidential and Privileged Information

I hereby authorize the mutual written and verbal exchange of any confidential or privileged information between Cliff Koblin MA, LPC, LCADC, and any Court and any Health, Education, or Legal Professional and any other person who, in Mr. Koblin's discretion, might be relevant to my contact with this office. Any exceptions to this exchange of confidential or privileged information are identified below.

I understand that Mr. Koblin, like most professionals, consults with other professionals as part of normal practice and mutual professional feedback and supervision, that he provides training and continuing professional education to other mental health professionals in which anonymous evaluation material is utilized, and that he uses professional test scoring services. I agree that this release also includes such professional consultation and training and the use of such services.

I understand that without this release my records are otherwise protected under the Federal and State Confidentiality Regulations and cannot be disclosed except in accordance with those regulations. I understand that it is my right to revoke this release at any time. I understand and agree that even if I revoke this release, the laws of the State of New Jersey require Mr. Koblin to disclose privileged information in situations of suspected child abuse, of suspected potential harm to oneself or another, and in instances where the court shall order the disclosure of privileged information or shall subpoena records.

I agree that a photocopy of this form and my signature below is as valid as the original.

In consideration of Mr. Koblin's agreement to perform this service for me, I hereby release Mr. Koblin, and each of the above parties with whom Mr. Koblin exchanges and/or releases information, from all liability, legal, professional, financial, or otherwise, that might directly or indirectly result from the release or exchange of any information that might be relevant to this consultation or evaluation. I fully understand, agree, and take sole responsibility that the information released may be detrimental and damaging to me personally, to me financially, and to me legally. I understand and agree that this is a legally binding document, that I have had the opportunity to consult with an attorney on this matter if I desire, that I fully understand the rights and privileges that I now waive by signing this agreement, and that I give this release, authorization, and consent of my own free will.

Any Exceptions not included in release:

[ ] Check, if no exceptions.

Signature: ____

Printed Name: ____

Signature (Child, 13 years or older) _________________________

Printed Name:

Executed this _____day of _________, 20____ in Kingston, Somerset County New Jersey