

## **Stress and Anxiety Services of New Jersey, LLC**

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A-2 Brier Hill Court  
East Brunswick NJ 08816  
www.StressAndAnxiety.com

Phone: (732) 390-6694  
Fax: (732) 432-7206  
e-mail:SAS@StressAndAnxiety.com

### **Instructions for Release of Information Forms**

The following form should be printed out and filled out for as many persons as is relevant. Please bring them in with you to your first appointment. This is how many forms you will need to print and fill out.

You will need one form for your insurance company. Even though we are not a member of your insurance or managed care panel, these companies often require us to send them information, fill out forms, or answer their phone calls in order for them to approve your sessions. Filling in their company name, address and telephone number and signing this form allows us to keep it on file and saves you time later on.

You will need one for the physician (usually a psychiatrist) who is prescribing psychiatric medication if you are taking any.

You will need one for any current or very recent therapist that you have seen, or are presently seeing.

Signing these forms for other mental health professionals allows us to contact them as needed, allowing us to all better serve you as a coordinated team.

So, again, please print out the number of forms you require, fill them out completely (leaving blanks if you do not know all the information) and bring in with you for your first session.

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## Release of Information Authorization-Minors

I, (name) \_\_\_\_\_, the parent/legal guardian of (name of child)  
\_\_\_\_\_, whose birthdate is (DOB) \_\_\_\_\_, and who lives at  
\_\_\_\_\_

do hereby authorize Stress and Anxiety Services of NJ, P.A. (or SAS of NJ) to release any information about this child deemed necessary to the following:

\_\_\_\_\_

located at \_\_\_\_\_

telephone number (\_\_\_\_\_) \_\_\_\_\_.

I also authorize the above indicated person/facility to release information to SAS of NJ.

Such information may include:

\_\_\_\_\_ open communication in order to facilitate and coordinate treatment services

\_\_\_\_\_ diagnostic interview \_\_\_\_\_ treatment summary \_\_\_\_\_ other

I understand that all the information released will be handled confidentially, in compliance with N.J.S.A. 45:14b-28. Federal Regulation CFT-Part 2 prohibits you from making any further disclosure without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization of release of medical or other information is NOT sufficient for this purpose. I understand that I may revoke this consent at any time.

\_\_\_\_\_  
Client signature, including minors 14 years and older, whose refusal to sign renders this consent void.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/legal guardian of minor or authorized representative in lieu of client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Date

\_\_\_\_\_  
Date