**Kristin M. O'Gara, M.S.W., L.C.S.W.**
License #44SCO4811000 Tax ID #01-0804181
**509 Main Street, Bldg. C**
**Toms River, NJ 08753**
Phone: 732.513.8258

# Release of Information Form

I, _____, whose Date of Birth is _____, authorize Kristin M. O'Gara, MSW, LCSW, to disclose to and/ or obtain from:

_____ the following information:

Description of Information to be disclosed:

*(Initial each item to be disclosed)*

| | | | |
|---|---|---|---|
| | Assessment | | Nursing/Medical Information |
| | Diagnosis | | Toxicological Report/Drug Screen |
| | Psychological Evaluation | | Educational Information |
| | Psychosocial Evaluation | | Discharge/Transfer Summary |
| | Psychiatric Evaluation | | Continuing Care Plan |
| | Treatment Plan or Summary | | Progress in Treatment |
| | Current Treatment Update | | Demographic Information |
| | Medication Management Information | | Session Notes |
| | Presence/Participation in Treatment | | Other: |

Purpose

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 purposes, please specify:

_____

Revocation

I understand that I have a right to revoke this authorization at any time by giving written notification to Kristin M. O'Gara, MSW, LCSW. I further understand that a revocation of the authorization is not effective to the extent that action has been taken to rely on the authorization.

Expiration

Unless sooner revoked, this consent expires on the last date of treatment or as otherwise indicated.

Conditions

I further understand that Kristin M. O'Gara will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:

_____

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, Kristin M. O'Gara, MSW, LCSW, reserves the right to disclose information as permitted by this authorization in any matter she deems to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

I understand that I have the right to inspect and copy the information to be disclosed. I will be given a copy of the authorization for my records.

_____ _____

*Signature of Client* *Date*

_____ _____

*Signature of Parent, Guardian or Personal Representative* *Date*

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.):

___ Check here if client refuses to sign authorization

_____ _____

*Signature of Therapist* *Date*