Lynn Schiller LLC
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Summit, NJ 07901
973-410-8596

Authorization To Release Information:

This form when completed and signed authorizes me to release and / or receive information from your clinical record to the named designee.

I, hereby authorize Lynn Schiller, Ph.D. to (initial one):

___Discuss my treatment

___Discuss my child's treatment – Child's name:___________________

___Other:__________________

This information may be shared with the following people and/or organizations:

I request that Lynn Schiller, Ph.D. release my information to help facilitate my treatment. This signed authorization will remain in effect until treatment ends, unless I exercise my right to revoke it prior to then. Should you choose to revoke this authorization you must do so in writing.

____________________________ __________
Signature of Patient or Guardian Date

____
Printed Name of Patient or Guardian

____
Relationship to Patient