

**Deborah Drumm APN, BC
Psychiatric Nurse Practitioner
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AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, authorize

___ Deborah Drumm APN, BC or ___ Deb Mccarren LPC to:

___ OBTAIN ___ DISCLOSE ___ VERBAL EXCHANGE

The following information with:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Date of Birth: _____

Please check all that apply:

1. ___ Admissions and discharge summaries
2. ___ Diagnosis
3. ___ Pertinent medical and psychiatric information relevant to my diagnosis and treatment.
4. ___ Pertinent alcohol and drug abuse treatment information
5. ___ Other information _____

For the specific purpose of: _____

Date of last contact with provider above: _____

The authorization will expire one year from the date of my signature. I understand that this authorization may be revoked by me in writing at any time, except to the extent that action has already been take.

Patient's signature: _____ Date: _____

(parent/guardian, if minor) _____

Witness: _____