Ronald E. Schroeder, Ph.D.

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AUTHORIZATION / CONSENT FOR DISCLOSURE OF PATIENT INFORMATION OR COMMUNICATION

I, _____ (DOB: _____), hereby authorize Ronald E. Schroeder, Ph.D. to disclose information and/or receive information to the extent or nature indicated below to/from _____ for the purpose of coordination of psychiatric and psychological treatment.

The information to be disclosed and/or received shall be limited to that information necessary to fulfill the above-stated purpose and may only include general summarized statements of my participation in treatment, objectives and goals of treatment, and prognosis. The release of clinical notes, and other psychological records is not authorized by this consent.

I understand that in New Jersey the communications between patients and mental health practitioners are privileged and confidential and, in most instances, may only be released with my written consent. I also understand that I may revoke this consent at any time except to the extent action has been taken in reliance thereon. This consent is effective immediately. I also understand that I may revoke my consent by writing to Dr.Schroeder and withdrawing my consent. This consent is for the above stated purposes only and specifically does not authorize the release of documents or information therein to any other party. A photocopy of this consent form is as good as the original.

I hereby release Dr. Schroeder, his/her employees, personnel, and professional health care providers from any and all legal responsibility or liability resulting from the release of the above information to the extent indicated and authorized herein.

_____ _____

Signature Date