OLIVE BRANCH
THERAPY

East Brunswick Office
63 Milltown Road
East Brunswick, NJ 08816

Somerville Office
21 E. High St.,
Somerville, NJ 08876

Please see the following instructions below to complete the Release Of Information. If all fields are not completed properly the release is not valid and will have to be completed again.

Section 1. Indicate who the information is being released to: Please include full name, mailing address, contact phone number, fax number and email.

Section 2: Indicate approximate dates of service this release is covering. **Section**

3: Indicate what information is being released. Check all boxes that apply.

Section 4: Select reasoning, check all boxes that apply.

Section 5: The expiration will always be one year from the current date. So if you completed the form on 1/1/2026 the expiration would be **1/1/2027.**

Once all sections of the release are completed, the client and therapist must both sign it with an original (not typed) signature and date. The release can be emailed directly to the Olive Branch therapist or handed in during the session. The therapist will input the completed release form into the client file.

*Please note, an ROI cannot be amended once signed.

I _____ _____

Client Full Name **Client Date of Birth(xx/xx/xxxx)**

Hereby authorize the Olive Branch Therapy Group to release information contained in my client records to the following individual(s) and/or organizations(s), and only under the conditions below:

1. Name of person(s), organizations(s), address to whom disclosure is to be made:

Full Name:

Relation to Client:

Phone Number(s):

Address:

E-mail:

Fax (if document is being faxed):

2. Approximate dates of service at site from which information is requested:

_____

3. Information to be disclosed: (check all that apply)

▢ Diagnosis ▢ Drug/Alcohol History ▢ Treatment Summary ▢ Attendance ▢ Mental Status Exam ▢ Entire Record ▢ Progress ▢ Physical Examination ▢ Prognosis ▢ Discharge Summary ▢Billing ▢Other (Indicate the other reason)_____

4. Purpose of disclosure: (check all that apply)

▢ Provision of Mental Service ▢ Billing Purposes ▢ Aftercare Planning
▢ Continuity of Treatment ▢ Family Involvement ▢ P.O./Attorney/ Judge/Court

5. This release will expire on **(Please put 1 year from current date xx/xx/xxxx)**:_____

I understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the contact person at BUSINESS except to the extent that action has already been taken to release this information. I have a right to inspect a copy of the health information to be released and if I do not sign this Authorization, the institution named above will not release my health information. The above named person/institution will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others. If I refuse to release information, it may negatively impact my quality of care in that providers will not be able to coordinate care between each other, which may limit my recovery. RE-DISCLOSURE: Notice is here-by given to the patient or legal representative signing this Authorization and the recipient named above that the health information disclosed under this Authorization might not be re-disclosed by the recipient to others without the written consent of this client. Federal law, rules and regulations prohibit the recipient from further disclosing any health information that may be included regarding diagnosis or treatment for Mental illness, HIV or drug/alcohol abuse.

_____ _____

Client (Parent/Guardian) Signature Date

_____ _____

Therapist Signature Date