Psychological Services and Care
14 Trumbull Street • New Haven, CT 06511 • 646.902.4357 • april@psychservicesandcare.org

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMAITON

I, _____, of _____
(name of patient OR guardian/relationship) (patient address)
give permission to Psychological Services and Care/Dr. Ries and _____
(Agency/Individual)
to exchange any medical, psychiatric, academic, substance abuse treatment, or other types of information deemed appropriate concerning _____, date of birth_____for the purpose of
(name of patient) (patient DOB)
facilitating treatment.

AGENCY/INDIVIDUAL NAME: _____
ORGANIZATION: _____
MAILING ADDRESS: _____
PHONE/FAX: _____

Dates of treatment_____and/or specific information to be releases:

[]Psychological Assessments and Reports []Medical Records including Dx

[]Treatment Plans/Summary []School Record

[]Verbal Contact []Written Contact Email

[]Other _____

I understand that my records are protected under the Federal and State Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time to the extent that action has been taken in reliance on it and that in any event that this consent will expires as described below.

Specification of the date, event, or condition upon which this consent expires on _____ or within 180 days from signature, whichever comes sooner.

I further acknowledge that the information that will be released was fully explained to me and this consent is given of my own free will.

Executed on this _____day of _____, 20___.

Client Signature_____ Date_____
Guardian Signature_____ Date_____
Witness Signature_____ Date_____