THE CENTER FOR PSYCHOTHERAPY, INC.
At ● Essex ● Guilford ● Old Lyme

Serving the mental health needs of the Shoreline communities
Central Office: 28 Main Street, Essex, CT 06426 ● Ph (860) 767-1517 ● Fax (860) 767-7703

AUTHORIZATION TO OBTAIN INFORMATION

I, ____ authorize ____ to release to the Center for Psychotherapy, Inc. and/or the treatment provider the following information: ____ ____ from the medical or mental health record of __________________________________. The dates of treatment covered by this release are as follows:______________________.

I understand that the medical or mental health record to be released may contain information pertaining to psychiatric and/or substance abuse diagnosis and treatment, and may also contain confidential HIV (AIDS) – related information. I understand that the information released by this consent shall not be further released in any way to any other person, entity, or others without additional written consent from me. I understand that I may withdraw this consent at any time prior to the release of the above information. This consent, if not withdrawn, will expire on _________________________ or 180 days from the date below.

____ ___________________
Patient Signature Date Signed

Patient's Date of Birth:_______________________

____ _________________________
Guardian's Signature Witness

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