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 RELEASE PATIENT INFORMATION

I, ____ authorize

____ to release the following written or verbal information:

_____ Psychological Evaluation
_____ Discharge or Transfer Summary
_____ Medication History
_____ Treatment Summary
_____ Letter, Specify:____________
_____ Other, e.g. Dates of Treatment
____

To: _______________________________ *(Name, Address, & Phone Number*

_______________________________ *of Person or Agency to Receive*

_______________________________ *Information)*

This information will be released for the following purpose (any other use is prohibited):

____

The dates of treatment covered by this release are as follows:_____________________

I understand that the medical record to be released may contain information pertaining to psychiatric and/or substance abuse, diagnosis, and treatment. 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 This consent, if not withdrawn, will expire on _________________ or 180 days from the date below.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 (patient is legal minor) Witness

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