GreenwichPsychPC

Release of Information

I hereby authorize: ☐ _____ from Greenwich Psych, PC

To: Name: _____
Address: _____
☐ Exchange information with: _____
_____
Telephone: _____

The information requested or authorized for release or exchange pertains to:

- ☐ Mental Health
- ☐ Psychiatric
- ☐ Sexually transmitted diseases
- ☐ Drug or alcohol abuse
- ☐ Education

☐ All the Above

This authorization is valid for the duration of the treatment from the date below. I may cancel this authorization by signing, dating, and writing "CANCEL" on this original form or by sending a written, signed and dated request to the doctor above indicating my desire to cancel. I understand that once my information has been released, the recipient might re-disclose it, my doctor has no control over it and privacy laws may no longer protect it. The purpose of this authorization is to improve the quality of my mental health evaluation or treatment.

_____ _____
Patient's Name Date of Birth

_____ _____
Patient's Signature Date

_____ _____
Guardian's Signature (if patient is a minor) Date