Wine Trail Behavioral Health, LLC.

2 Bartholomew Lane, Wallingford, CT.
203-317-7446

AUTHORIZATION TO RELEASE PATIENT INFORMATION

I, _____
authorize
_____ to release the
following written or verbal information:

_____ Psychological Evaluation _____Treatment Summary
_____ Discharge or Transfer Summary _____ Letter, Specify: _____
_____ Medication History _____ 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 This consent, if not withdrawn, will expire on _____ or 180 days from the date below.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's Signature Date

Patient's Date of Birth: _____

_____ _____
Guardian's Signature (patient is legal minor) Witness