Wine Trail Behavioral Health, LLC.

2 Bartholomew Lane, Wallingford, CT 06492
203-317-7446

AUTHORIZATION TO OBTAIN INFORMATION

I, _____
authorize
_____ to release to Wine Trail

Behavioral Health, LLC. 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 This consent, if not withdrawn, will expire on _____ or 180 days from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