GREATER SPRINGFIELD COUNSELING, PC

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East Longmeadow, MA 01028
Phone: 413-567-9993
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Authorization to Release Information

Name: _____ Date of Birth: _____

I hereby authorize _____ to

☐ Obtain from ☐ Release to

Name: _____

Address: _____

_____

the following information for the time period of _____ to _____, inclusive:

__ Admission Notes __ Discharge Summary __ Patient History

__ Medication Information __ Progress Notes __ Test Reports

__ Case Summary __ Attendance Record Only

__ Continuing exchange between _____ and _____

__ Other: _____

This information is needed for _____

I understand that this information is confidential and agree that I am voluntarily consenting to its release. I also understand that I can withdraw this release at any time by given written, dated notification. This authorization will automatically expire 180 days from the following date:

_____ _____

Signature of client, responsible person or parent if the client is a minor

Date

_____

Witness