**AUTHORIZATION FOR RELEASE OF INFORMATION**

**I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_authorize NWHYFS to**

**OBTAIN and/or RELEASE pertinent information regarding Myself &/Or My Child**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FROM/TO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone: Fax: Email:**

**Make all that apply below:**

**\_\_\_\_Admission Notes \_\_\_\_Psychiatric Assessment**

**\_\_\_\_Discharge/termination summary \_\_\_\_Clinical Records**

**\_\_\_\_Psychosocial History \_\_\_\_Psychological Evaluation**

 **\_\_\_\_ Academic Records \_\_\_\_Phone Consultation**

 **Other (please specify): Discussion of care support for continuity of care**

**This permission commences on \_\_\_\_\_\_\_\_\_ and expires on \_\_\_\_\_\_\_\_\_. I understand that I may withdraw this consent at any time prior to the release of this information. It is my understanding that this information will be used solely for the purpose of enhancing therapeutic treatment.**

**It is my understanding that all such communications will remain confidential and will not be shared with outside sources to the extent provided by law.**

**Contact Person: Mary Ann Cheney, LMFT Address:20 Main Street, #8 Oakville, CT 06779 Phone: 203-415-8066 / Fax: 860-799-4156/ maryann.cheney@nwhyfs.org**

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**Signature of Client or Responsible Party Witness**