276 South Main St.
Colchester, CT 06415
(860) 917-8316

Authorization for the Release of Information

Client Name: ____ Date of Birth: ___________________

I authorize Healthy Outlook Counseling to disclose to and/or obtain the following information from:

____

Specified Information to be Released:

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I understand that the purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. I understand that I have the right to revoke this authorization at any time by sending written notification to Healthy Outlook Counseling. I further understand that a revocation of the authorization will not affect any information released between the time of the authorization and revocation. I authorize the disclosure of above specified information in any manner that Healthy Outlook Counseling deems to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically. This consent will be in effect beginning on the date of signature.

Unless sooner revoked, this authorization expires on the following date: ___________________________

____

Signature of Client Date

____

Signature of Parent, Guardian or Legal Representative Date

____

Signature of Staff Witness Date