New Horizon Living Centers, Inc.

34 Fallsbrook Rd
Bristol, CT 06010
860-584-2105

Authorization for Release of Information

I _____ hereby authorize New Horizon Living Centers to Disclose /Obtain the following information regarding myself to (**Must include complete name and address of person receiving to be valid)**
Name: Any person deemed necessary by Dr William Crandall
Address: 34 Fallsbrook rd Bristol Ct. 06010
Phone: 860 584 2105

Client/Guardian Please INITIAL the appropriate items:

	Obtain	**Release**	
Verbal Release _____	_____	_____	Service/Termination Summary
Written Release _____	_____	_____	Psychological Evaluation
Electronic Release _____	_____	_____	Date of admissions Discharge
	_____	_____	Diagnosis
	_____	_____	Education/School Information
	_____	_____	Other (Specify) _____

_____

Client Date of Birth_____ Client SS# _____

For The Purpose Of _____

The confidentiality of this record is required under Chapter 899 of the Connecticut General Statutes as Well as title 42 of the United States Code. This material should not be transmitted to anyone without the client's written consent or authorization as provided for in these Statutes. I understand that the medical record to be released may contain information pertaining to psychiatric, drug, and/or alcohol abuse diagnosis and treatment, and may also contain confidential HIV (AIDS) related information.

I understand that I may withdraw this consent at any time prior to the release of the above information.

This consents if not withdrawn will expire 364 days after the date of signature.

I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the patient and thus may no longer be protected by federal privacy regulations.
I understand that I may inspect or copy the information to be used or disclosed.

_____ _____
Signature of Client/Authorized Guardian Date

_____ _____
Signature of Witness Date

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