LANDMARK CENTER
FOR BEHAVIORAL HEALTH

1062 Barnes Road, Suite 207
Wallingford, Connecticut 06492
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AUTHORIZATION OF RELEASE OF RECORDS OR INFORMATION

I (we) the undersigned authorize and request *David A. Krulee, M.D.* to release/obtain confidential professional information, including personal, psychological and psychiatric records and opinions, and privileged communications, from the record of:

_____ _____/_____/_____
(Patient Name) (DOB)

__**Disclose information to:** AND/OR __**Obtain information from:**

_____
(Name of agency, attorney, school counselor, therapist, etc.)

_____
(Address, city, state and zip code)

Phone: ( )_____ Fax: ( )_____

___**MY ENTIRE RECORD;OR**

__**Only the following information: (Please initial each item to be released/obtained)**

____Psychiatric Evaluation ___Diagnosis / Assessment

____ Progress Notes ___ Treatment Plan

____Other (specify):_____

I understand that the records to be released may contain information pertaining to psychiatric, drug and/or alcohol abuse treatment, and may also contain confidential HIV (AIDS) related information.

FORM IN WHICH INFORMATION SHOULD BE RELEASED: ___**VERBAL** ___**COPY**
___**WRITTEN**

I MAY REVOKE THIS CONSENT AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE UPON IT. If I do not revoke it, this consent will expire one (1) year after I have terminated treatment with all providers.

_____ _____
Signature of patient ***Signature of parent, guardian or authorized representative***

_____ _____
Date ***Witness***

I understand that further disclosure of the information to be disclosed may not be made without my written consent or as otherwise restricted by Federal Regulations (42 Code of Federal Regulations, Part 2, confidentiality of Alcohol and Drug Abuse Treatment Patient Records).