**SPECTRUM PSYCHIATRIC GROUP, P.C.**
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| | | |
|---|---|---|
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| __Anthony Colombrito, LPC | __Kathryn Snow, LCSW | __Kelly Vanasse, APRN |

__Other provider, specify: ___________________________________

## Authorization for the Release of Confidential Information

Psychiatric Records, Alcohol and Drug Records and / or Medical Records

| ___________________________ | ____________________ | ___________________ |
|---|---|---|
| Patient Name | Date of Birth | Social Security Number |

I hereby authorize this agency and its staff to __obtain or __disclose verbally or in writing the following information: (Check appropriate box or boxes)

| | | |
|---|---|---|
| __psychiatric diagnosis only | __laboratory date-urinalysis results | __educational evaluations |
| __dates of admission & discharge | __medical evaluation | __current school adjustment |
| __intake & assessment summary | __Physical examination finding | __any other data custodian of Record deems appropriate |
| __psychiatric evaluation | __psychological testing | |
| __discharge summary | __drug abuse or alcoholism info | __other (specify) |
| __progress notes | __HIV/AIDS information | |

From/To: ______________________________________________________________
(Person or Agency Name)

Address: ______________________________________________________________

Telephone: ________________________________ Fax: _________________________

**For the purpose of (check appropriate box or boxes)**

| | | |
|---|---|---|
| __coordination of care | __return to duty evaluation | __disability determination |
| __vocational rehabilitation | __treatment & discharge plan | __educational planning |
| __legal matters | __insurance authorization/claims processing | |
| __employment-related/EAP | __other (specify)________________ | |

I understand that my medical records are protected by Federal and State Confidentiality Statutes – Connecticut Chapter, 899, PL 93-579 General Statutes. This material shall not be transmitted to anyone without written consent or other authorization as provided in the aforementioned statues. I also understand that I may revoke this consent at any time, except to the extent that action has already been taken. The revocation of this consent form requires written notification from the patient or the legal guardian of the patient.

The information to be obtained or disclosed was fully explained to me and was given of my own free will. I understand the medical record to be released may contain information pertaining to psychiatric, drug and/or alcohol diagnoses and treatment, and may also contain confidential HIV/AIDS related information.

| ______________________________________________ | ______________________ |
|---|---|
| Patient signature (for 15 year and older) | Date |
| ______________________________________________ | ______________________ |
| Parent or Legal Guardian Signature (under 18 years) | Date |
| ______________________________________________ | ______________________ |
| Witness signature | Date |