RELEASE OF INFORMATION

Patient Name:_____ Date of Birth:_____

I hereby authorize Alison Wittenberg, APRN to disclose to and/or obtain from _____

_____the following information:
(Name and contact information of person/organization)

_____Assessment/Diagnosis
_____Psychosocial Evaluation
_____Psychological Evaluation
_____Psychiatric Evaluation
_____Treatment Plan or Summary
_____Progress/Current Treatment Update
_____Psychotherapy Notes*
(*Must be separate disclosure)
_____Other:_____

_____Nursing/Medical Information
_____Educational Information
_____Discharge/Transfer Summary
_____Continuing Care Plan
_____Demographic Information
_____Medication Management Information
_____Toxicology Reports

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 a right to revoke this authorization, in writing, at any time by sending written notification to Alison Wittenberg, APRN. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Unless sooner revoked, this authorization expires 60 days after the last documented treatment service date, or as otherwise indicated:_____.

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. Other types of information may be re-disclosed by the recipient of the information in the circumstances outlined in "Notice of Privacy Practices" I have been provided and read at intake.

Upon request, I will be given a copy of this authorization for my records.

Signature of Patient/Client Date

Signature of Patient/Client Date

Alison Wittenberg, APRN, PMHNP, LLC
133 State St. Guilford CT 06437