Family Resource and Development Center, LLC
270 Farmington Avenue, Suite 347
Farmington, CT 06032
Ph: (860) 838-4735
Fax: (860) 507-7480
Website: www.frdcllc.com
Email: frdcllc@gmail.com

Authorization to Obtain/Release Information

Patient: _____
Date of Birth: _____

Information being Obtained/Released:

_____ Phone Contact (specify content) _____
_____ Psychiatric Evaluation/Psychiatric Progress Reports
_____ Clinical Assessment, Treatment Plan and/or Notes
_____ Letters Regarding Treatment Needs/Issues
_____ Email Containing Clinical Information

This authorization permits the sharing of the above-identified information between the staff of Family Resource and Development Center, LLC and:

_____
_____
_____
Phone: _____
Contact Person: _____

I understand that the information being obtained/released is for the purposes of treatment planning. I understand that I may withdraw this consent at any time prior to the release of the above information and that withdrawal of this consent must be done in writing. I understand that refusal to grant consent will not impede my right to obtain present/future treatment so long as the disclosure is not deemed as necessary for providing appropriate clinical care. This consent will expire on _____ or 6 months from the date of signature.

Signature of Patient _____ Date _____
(required for all patients 16 years and older; 14 years and older with substance abuse diagnosis)

Signature of Parent/Guardian _____ Date _____
(Required for all patients under the age of 18; "guardian" must provide verifying documentation)

Signature of Witness _____ Date _____