CPC Associates Inc.

84 Hospital Avenue
Danbury, CT 06810
Telephone (203) 792-0400

AUTHORIZATION TO RELEASE/RECEIVE INFORMATION

This release is to authorize CPC Associates Inc. to release, communicate, or receive written and verbal information (including medical and psychotherapy records, psychiatric, psychological, or education evaluations, school records, intake and/or discharge summaries, and treatment plans) from the record of:

Patient: ___________________________________ **(please print name)**

To / From:

PCP ____

School ____

Insurance Company ____

Other ____

Other ____

It is my understanding that the information may be used for clinical study, diagnosis, treatment and/or condition for payment by third party payers.

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.

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

If not revoked by me, this authorization will expire 90 days from the date noted below.

____________________________ Signature of Patient

____________________________ Signature of parent of guardian (If patient is under 18 years of age)

Date: ____________________

____________________________ Signature of Witness

Print Name of Witness ____________________________

Prohibition of Redisclosure:

This information is protected by Federal law. Federal regulation (42 CRF Part 2) prohibits further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be fined.