Break Free
CENTER FOR WELLNESS, LLC

Sharron Riley-Seymour
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RELEASE OF INFORMATION

I, _____, date of birth _____, authorize Sharron Riley-Seymour, LPC, 642 Hilliard Street, Suite 1223, Manchester, CT 06042, to ☐ make and/or ☐ receive disclosures to and from:

Name of Contact: _____ Agency: _____

Address: _____

_____

Phone Number: _____ Fax Number: _____

The type of information to be disclosed:

☐ Admission information (including diagnosis)
☐ Attendance, Treatment Compliance
☐ Discharge Information
☐ Treatment Plan/Progress
☐ Psychotherapy Notes
☐ Other: _____

The purpose of this disclosure is:

☐ Ongoing Treatment
☐ Evaluation
☐ Coordination of Care
☐ Medical Care
☐ Transfer
☐ Other: _____
☐ Consultation
☐ Legal Issues

Authorized methods of communication:

☐ Phone ☐ Fax ☐ Electronic mail ☐ Mail

I understand that I may revoke this consent for future treatment and that it cannot be revoked retroactively. This release will be valid for one year from the date of signing. I understand that once information has been disclosed subject to this authorization, the information may be subject to re-disclosure and no longer be protected by state or federal law.

MENTAL HEALTH RECORDS: In the event that information released constitutes privileged mental health patient communications, the confidentiality of this record is required under Chapter 899 of the Connecticut General Statutes. This material shall not be transmitted to anyone without written authorization as provided in the aforementioned statues.

DRUG & ALCOHOL ABUSE RECORDS: In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Record regulations: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

AIDS OR HIV RELATED INFORMATION: This information has been disclosed to you from records protected by State Law. Connecticut State Law prohibits you from making any further disclosures without the written consent of the patient or as otherwise permitted by law.

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____