AUTHORIZATION FOR RELEASE OF INFORMATION ***

Name:____

Date of Birth:____________________________________

For the purpose of continuity of care I request that information from my psychiatric record be obtained or shared with:

____
____
____
____

And released to Rosemary Huber, LPC.

6515 Main Street, Suite 6LL
Trumbull, CT 06611
rosemaryhuberlpc@gmail.com
(860) 980-0405

The record to be released may contain information pertaining to medical, psychological, psychiatric, HIV/AIDS, drugs and/or alcohol diagnosis and treatment.

The confidentiality of this record is required under Chapter 899 of the Connecticut General Statutes as well as Title 42 of The United States Code. This material shall not be transmitted to anyone without written consent or authorization as provided in these statutes.

Signature of the Patient, Parent or Legal Guardian:___________________________________

Date:____

Witness:____

***This authorization may be revoked at any time except to the extent that action has already been taken in reliance upon it. Unless withdrawn, this authorization expires 1 year from the date of signature above.

Rosemary Huber, LPC
Counseling + Psychotherapy