

Daniel Weiner, MA LPC, LLC

15 North Main Street, 2nd Floor

West Hartford, CT 06107

Phone: (860) 677-0028

Fax: (860) 752-6072

Email: daniel.weiner@comcast.net

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 Daniel Weiner, MA LPC, 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 _____
(required for all patients 16 years and older; 14 years and older with substance abuse diagnosis)

Date _____

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

Date _____

Signature of Witness _____

Date _____