Old Saybrook Youth & Family Services
322 Main Street, Old Saybrook, CT 06475
(860) 395-3190 ◆ FAX (860) 395-3189

REQUEST/AUTHORIZATION TO RELEASE CONFIDENTIAL RECORDS AND INFORMATION

I hereby authorize
Person or facility_____
_____

to release information from records about _____, born on, _____

to _____
_____

for the following purposes:

[ ] Further mental health evaluation, or care [ ] Treatment planning [ ] Other _____
_____

This is a [ ] one-way release of information [ ] two-way release of information *(check only one)*

The information to be disclosed is marked by an X in the boxes below, and the items not to be released have a line drawn through them.

[ ] Intake and discharge summaries [ ] Medical history and evaluations [ ] Mental health evaluations [ ] Developmental and/or social history [ ] Educational records or classroom behavior and issues [ ] Progress notes, and treatment or closing summary
[ ] Other_____

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time except to the extent that action based on this consent has already been taken. This consent will expire automatically on _____ or upon fulfillment of the purposes stated above.

_____	_____	_____
Signature of client	Printed name	Date

_____	_____	_____	_____
Signature of parent/guardian	Printed name	Relationship	Date

_____	_____	_____
Signature of witness	Printed name	Date