Christopher Greene, LCSW
44 Long Hill Road, Guilford, CT 06437
Voice/Facsimile: 203-453-0812
christopher.greene@comcast.net

Authorization for the Release of Family Information

Name: _____ Date of Birth: _____

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We authorize **Christopher Greene, LCSW** to disclose to, and/or obtain the following kinds of information from:

Kinds of Information	Recipient
✷ Demographic Information and History ✷ Psychiatric, PsychologicalEvaluations ✷ Psychosocial or Educational Evaluations ✷ Legal History ✷ Pending Legal Actions (Criminal and Civil) ✷ Toxicological Reports and Drug Screens ✷ Assessment and Diagnosis ✷ Medication History ✷ Current Medication Regimen ✷ Current Treatment Progress, Prognosis and Plan ✷ Discharge and/or Transfer Summary	_____ Clinician or Healthcare Institution _____ Street Address _____ City, State, Zip Code _____ Phone Number

The purpose of this disclosure of information is to improve assessment, treatment planning, treatment and, as relevant, to coordinate multiple treatments.

We understand that we have a right to revoke this authorization, in writing, at any time, but we also understand that a revocation of this authorization is not retroactive, and that it cannot apply to information that, at the time of the revocation, has already been disclosed because of this authorization.

Unless sooner revoked, this authorization expires at the end of our treatment with Mr. Greene.

_____ _____
Signature Date

_____ _____
Signature Date