Release of Information

I, ______________________________________ whose Date of Birth is _________________,
[Insert Name of Patient/Client],

authorize William F. Mecca, Sr. LCSW, LMFT, LADC to disclose to and/or obtain from:

____ the following information:

Description of Information to be Disclosed

(Patient/Client should initial each item to be disclosed)

_____ Assessment
_____ Diagnosis
_____ Psychosocial/Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Presence/Participation in Treatment
______Nursing/Medical Information

_____ Toxicological Reports/Drug Screens
_____ Educational Information
_____ Discharge/Continuing Care/Transfer Summary
_____ Progress in Treatment
______Alcohol/Drug Information
______Other______________________

Purpose
The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

If other purpose, please specify: ____.

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to William Mecca at 547 Evergreen Avenue, Hamden, CT 06518.

Expiration
Unless sooner revoked, this consent expires on the following date: _______________ or as otherwise indicated:____.

I further understand that William F. Mecca, Sr., LCSW, LMFT, LADC will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:
____

Form of Disclosure
Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

I understand that I have the right to inspect and copy the information to be disclosed.

____
Signature of Patient/Client Date

____
Signature of Parent, Guardian or Personal Representative Date

____
Signature of Clinician/Witness Date