Vanessa Weinbach, Ph.D.
Clinical Psychologist, Lic. 3681
6 Riverfield Dr., Westport, CT 06880 ~ 203.343.4208

Authorization for release of information

I, _____, (_____), do hereby authorize Vanessa Weinbach, Ph.D.,
First, Middle, Last Name DOB
to exchange information contained in my medical record, in either verbal or written form, and/or by fax, to and from:

Name of Person or Agency: _____

Address: _____
Street Address City State ZIP

Telephone: _____ Fax Number: _____

Permission is hereby granted to provide information to the above specified person(s) or agency regarding:

_____ COMPLETE RECORD _____ VERIFY TREATMENT ONLY
_____ TREATMENT SUMMARY _____ BILLING INFORMATION
_____ FOR PURPOSE OF: _____

I give permission for information to be released in written or verbal form, or via fax, to the above specified individual or to personnel at the above specified agency. I understand that this Authorization will expire one year from the date of signature below, unless specified otherwise. I understand that I have the right to request an accounting of any instances that information is released to other parties. I understand that this Authorization may be revoked at any time.

Signature: _____ Date: _____

FOR INTERNAL USE ONLY
(document here date and circumstance of any releases of information)

_____

_____

_____

_____

_____

DATE REVOKED: _____ Signature: _____