Greenwich Psychotherapy & Associates

30 Washington Ave,
Greenwich, CT 06830
T: 203-862-8940
F: 203-286-1653

Consent For Release Of Information

Patient Name: ______________________________

Date of Birth: ________ / ________ / ______________

I hereby authorize Greenwich Psychotherapy & Associates to:

Release Information To   Receive Information From

Person or Organization: ______________________________

Address: ______________________________

____

Phone: __________-__________-__________

Fax: __________-__________-__________

E-mail: ______________________________

For the purpose of coordinating treatment related to: ______________

____

This consent will be valid until Greenwich Psychotherapy & Associates confirms receipt of a written revocation of all or part of this consent. My revocation of this consent will not apply to any action Greenwich Psychotherapy & Associates has taken in reliance on this consent prior to receiving my written revocation.

______________________________   ______________________________

Signature of Patient/Guardian   Date   Signature of GPA Provider   Date