WCT Health & Wellness
Phone. 203.518.8218 Fax. 844.833.5610. Email info@wctbehavioral.com

Authorization for Release/Exchange of Confidential Information

I,_____, hereby authorize WCT Health & Wellness to release and/or exchange confidential information obtained during my treatment to:

Name:

Address: City: State: Zip:

Phone Number: Fax Number:

This Authorization permits the release and/or exchange of the following information (check all that apply):

- ☐ Dates of Treatment
- ☐ Diagnosis
- ☐ All Information Necessary
- ☐ Other (specify):
- ☐ Treatment Plan
- ☐ Prognosis
- ☐ Progress to Date
- ☐ Clinical Test Results

I authorize the release of the information described above for the following purpose(s):

The specific uses and limitations on the types of information to be released are as follows:

The specific uses and limitations on the use of the information by Recipient are as follows:

I understand that I have a right to receive a copy of this Authorization, and that any modification or revocation of this Authorization must be in writing. This release shall be valid until the termination of treatment or until withdrawn in writing by the patient during treatment.

Client's Printed Name:

Client Signature Date