CROSSROADS Behavioral Health

10 North Main Street ● West Hartford CT 06107 ● Tel: 860-233-8111 ● Fax: 860-236-2016

CONSENT TO DISCLOSE OR OBTAIN PSYCHOLOGICAL, MEDICAL AND/OR EDUCATIONAL RECORDS

____ _________________

Patient Name Date of Birth

I hereby authorize Susan E. Peterman, Ph.D. to **obtain or disclose** verbally or in writing information.

From/To: ____(Person/Agency)

____

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Telephone:_______________________ Fax:___________________________

The purpose of this release of information and the use to which the information will be put, will be to discuss and/or release medical, psychological, drug and/or alcohol, or educational information pertaining to the above-named patient.

I understand this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent. Consent may be withdrawn at any future time in writing addressed to Dr. Susan E. Peterman at 10 N. Main Street, Suite 204, West Hartford, CT 06107.

Specific Information Requested: ____

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Method of Disclosure: FAX MAIL VERBAL E-MAIL **(Please circle all that apply)**

The above-named patient has been or will be seen at this office. Would you kindly forward any material which would be helpful in working with this patient.

Date:_____________ Signed:____

(If minor, parent/guardian signature needed)

Witness:____