The Fresh Start Program
Waterstone Counseling Center

Dr. Thomas Abbenante, MD • Dr. Richard Goulding, MD
Dr. Marc F. Bono, Psy.D

CONSENT TO RELEASE/RECEIVE INFORMATION

_____ _____
Patient Name DOB

Please check box that applies:

Receive Information ☐ **Request Information☐**

To/From:

Name: _____

Address:_____

Telephone #:_____Fax#_____

For the Purpose of:

☐ **Continuity of Care**

☐ **Other:** _____

This request and authorization applies to:

☐ **All healthcare information**

☐ **Specific Healthcare Information as indicated** _____

By <u>INITIALING</u>, I specifically authorize the release of the following confidential information:

____ HIV test, test results and related information including high-risk behavior documentation.

____ Drug/Alcohol diagnosis, treatment or referral information

____ Mental Health treatment information

____ Other (specify) _____

17 Wall Street, Madison, CT 06443
p:203-245-0412 f: 203-245-0572

The Fresh Start Program
Waterstone Counseling Center

Dr. Thomas Abbenante, MD • Dr. Richard Goulding, MD
Dr. Marc F. Bono, Psy.D

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken on reliance on it. This consent will last while I am being treated for opioid dependence by the physician specified above unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

I understand that the records to be released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records less than 42 CFR Part 2, and I further acknowledge that I understand those rights.

_____	_____	_____
Patient's Signature	Patient's Name (Please Print)	Date

17 Wall Street, Madison, CT 06443
p:203-245-0412 f: 203-245-0572