

**GREENLIGHT AT WILKINS CENTER,LLC
7 RIVERSVILLE ROAD
GREENWICH, CT. 06831**

**AUTHORIZATION FOR RELEASE OF (MEDICAL AND PSYCHIATRIC)
PROTECTED HEALTH INFORMATION**

The information covered by this authorization includes all medical and psychiatric information and billing information pertaining to your treatment with the Greenlight at Wilkins Center program. This information may be used and/or disclosed by the physicians and staff pertaining to your care.

Please list the names and phone numbers of any private physicians, therapists and/or family members that you wish to have authorization to speak with the Greenlight providers.

If you wish to restrict your private medical information from disclosure to an individual or entity – please list the names and phone numbers below.

This authorization is effective through life unless revoked or terminated by the patient or the patient’s representative. You may revoke or terminate this authorization by submitting a written revocation to Greenlight at Wilkins Center, LLC.

Potential for re-disclosure of information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under federal privacy regulations.

Name of Patient _____ date of birth _____

Signature of Patient _____ date _____

Signature of Parent or Guardian if Patient is a minor

_____ date _____