Greenwich Medicine, LLC
Kasey Spoonamore, MD
38 Lake Avenue
Greenwich, CT 06830

AUTHORIZATION TO RELEASE INFORMATION

I, **(name of patient)** _____, (hereinafter "Patient") hereby authorize **Kasey Spoonamore, MD, Greenwich Medicine LLC**, (hereinafter "Provider") to disclose mental health treatment information and records obtained in the course of treatment, but not limited to, diagnosis of my condition, to:

_____
_____
_____

I also hereby authorize _____ to release information related to my treatment to Kasey Spoonamore, MD.

I understand that I have a right to receive a copy of this authorization Therapist shall not condition treatment upon Patient signing this authorization and Patient has the right to refuse to sign this form. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider at:

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This disclosure of information and records authorized by Patient is required for the following purpose:
_____

Such disclosure shall be limited to the following specific types of information:
_____
_____

This authorization shall remain valid for 180 days from today's date

Patient's signature: _____ Date:_____ Date of Birth_____

Print Name_____ Phone number_____