BENHAVEN

Benhaven Academy
50 North Plains Highway
Wallingford, CT 06492
www.benhaven.org
T: 203 774-0008
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AUTHORIZATION FOR THE RELEASE OF INFORMATION TO BENHAVEN ACADEMY

I_____, authorize _____
(Name of person granting permission) (name and address of person, institution, or organization in possession of records) to disclose to _____ information/records pertaining to:

_____
(**Name of person who is the subject of the record**) **(Date Of Birth)**

Type of information/records to be released (**check all that apply**):

☐ Psychiatric ☐ Psychological ☐ Medical ☐ Education ☐ Medication

☐ Psycho-therapy notes (NOTE: a request for psycho-therapy notes cannot be combined with a request for any other records).

☐ All of the above

☐ Other (**specify**)

This authorization/disclosure provides information to Benhaven Academy for use in case planning and development/implementation of an educational program or any other purpose for which this information can be lawfully used.

The nature and extent of the information to be disclosed is the entire record unless otherwise specified below: If not revoked, this authorization will expire on _____ or in one year, whichever occurs first.

_____ _____
Signature of person giving permission or authorized representative **Date**

Check if this form has been signed by a person other than the subject of the record:

☐ parent/guardian ☐ attorney ☐ guardian ad litem ☐ other (**explain**)

NOTE: Confidentiality of psychiatric, medical, and behavioral records is required, and no information from these specific records can be transmitted to anyone else without written consent or authorization.

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