Monarch Therapeutic Services, LLC
PO Box 8101, Manchester CT 06040-0101
Phone: 203.587.8650 **Fax**: 866.881.6464
Email: monarchpsychotherapy@gmail.com

RELEASE OF INFORMATION

Patient's Name: _____ Date of Birth: ____ / ____ / ____
Please Print Patient's Full Legal Name

For the purposes of assessment, collaboration and coordination of services, I hearby authorize:

Monarch Therapeutic Services, LLC

to obtain information from and/or release information to:

Name: _____
Organization: _____
Address: _____
Address: _____
Phone: _____ Fax: _____
Email: _____@_____

I understand that my authorization will remain effective for 12 months from the date of my signature and that the information will be handled confidentially in compliance with all applicable federal laws. I understand that I may revoke the authorization at any time by written, dated communication.

Patient's Signature_____ Date ___ / ___ / ___

Patient's Rep Signature_____Date ___ / ___ / ___

Patient's Rep Printed Name_____

Witness's Signature_____Date ___ / ___ / ___