Permission to Exchange Information Form

ACCESS Programs: (Please check one)

North (Torrington) ☐

South (Danbury) ☐

Date:
Re:
Birth Date:
Address:

I hereby authorize the exchange of pertinent information concerning the above-named for the follow purpose(s):

Psychosocial assessments	Psychological testing	Lab/consultations
Evaluation/testing	Coordination of services	Educational Planning
Discharge planning	Treatment planning	Legal Services
Physical exam/immunization records		
Other:		

To/From: EdAdvance
The ACCESS Program

To/From:

Address:

Parent/Guradian Signature:

Relationship:

Patient's Signature

The confidentiality of this record is required under the Connecticut General Statutes. This material shall not be transmitted to anyone without written consent or other authorization as provided in the aforementioned statutes This authorization may be withdrawn at any time by signed request, unless already acted upon and in process, or in any evert expires one year from date of signature.