Kristin C. Sopronyi, MS
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CONSENT FOR THE RELEASE OF CONFIDENTAL INFORMATION

Client Name: _____ Date: _____

I hereby authorize Kristin C. Sopronyi, MS, 525 Hercules Dr. Suite 1A, Colchester, VT 05446 to
☐ disclose to and/or ☐ receive information from:

Name: _____

Street Address: _____

City: _____State_____Zip_____

Phone: _____ Fax: _____ Email: _____

Affiliation/Relationship/Business: _____

I authorize the following information to be disclosed in written or verbal form:

- ☐ Current Status
- ☐ Treatment Progress
- ☐ Medical Condition
- ☐ Presence in Treatment
- ☐ Discharge Summary
- ☐ Psych/Social History
- ☐ Legal Information
- ☐ Medications
- ☐ Identified Concerns/Problems
- ☐ Substance/Alcohol Related Treatment Information
- ☐ Crisis Interventions
- ☐ Other: _____

I understand the purpose and need for such disclosure to be coordination of services. If there is another purpose for disclosure, it is fully explained below:

_____

_____

I understand that my records are protected and cannot be disclosed without my written consent unless otherwise provided for under informed consent. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. Unless revoked sooner, this consent expires:
☐ One year from this date ☐ One month following termination ☐ Other:_____

_____ _____
Client/Guardian Date Clinician Date