



Creative Potential, LLC
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AUTHORIZATION FOR THE RELEASE OF INFORMATION FROM
CREATIVE POTENTIAL, LLC

_____, authorize
(name of person granting permission)

Creative Potential, LLC, 1031 Norwich New London Tpk. Unit 10 Unicasville, CT. 06382 to disclose to

_____ information/records pertaining to
(name and address of person, institution, or organization)

(name and DOB of person who is the subject of the record/info)

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

- Psychiatric Psychological Scholastic/Academic Medical
Other (please explain: _____)

Purpose of authorization/disclosure:

The nature and extent of the information to be disclosed is the entire record unless otherwise specified below:

This authorization, if not cancelled, will expire on _____ or in one year, whichever occurs first.
(Date)

I understand that refusal to sign this authorization form will not affect my right to obtain present and future services, except where disclosure of the records requested is necessary for services. I also understand that I may revoke this authorization by notifying Creative Potential or the named recipient in writing. A revocation of this authorization will not apply to any records disclosed before the authorization is revoked.

Signature of person authorizing disclosure or authorized representative Date

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

- Parent/guardian Attorney Other (explain: _____)