

**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION**

Regarding:

Last Name	First	Middle	Date of Birth / /
Maiden name or other names known by			Social Security Number

I \_\_\_\_\_ authorize the following information to be disclosed:

**(PLACE YOUR INITIALS TO THE LEFT OF EACH ITEM APPROVED):**

Information to be released from:	Information to be released to:
<input type="checkbox"/> The Department for Children and Families (DCF) <input type="checkbox"/> School District: USD # _____ <input type="checkbox"/> Medical practitioner, clinic, center or facility  <input type="checkbox"/> _____ Mental health practitioner, clinic, center, or facility  <input type="checkbox"/> _____ Substance Abuse treatment provider  <input type="checkbox"/> _____ Social Service agency or provider  <input type="checkbox"/> _____ Subcontractor agencies providing services to child or family  <input type="checkbox"/> _____ Relatives/kin; prospective adoptive families (as applicable); all participants in the initial 24 hour meeting, family meetings and related case planning conferences and meetings  <input type="checkbox"/> _____ Other: _____ _____	<input type="checkbox"/> The Department for Children and Families (DCF) <input type="checkbox"/> School District: USD # _____ <input type="checkbox"/> Medical practitioner, clinic, center or facility  <input type="checkbox"/> _____ Mental health practitioner, clinic, center, or facility  <input type="checkbox"/> _____ Substance Abuse treatment provider  <input type="checkbox"/> _____ Social Service agency or provider  <input type="checkbox"/> _____ Subcontractor agencies providing services to child or family  <input type="checkbox"/> _____ Relatives/kin; prospective adoptive families; (as applicable); all participants in the initial 24 hour meeting, family meetings and related case planning conferences and meetings  <input type="checkbox"/> _____ Other: _____ _____

Information to be released **(PLACE YOUR INITIALS TO THE LEFT OF EACH ITEM APPROVED):**

<input type="checkbox"/> All Information necessary for DCF/CWCMP to provide services requested. <input type="checkbox"/> All academic, achievement or aptitude evaluations and recommendations <input type="checkbox"/> Social, behavioral, psychological, mental or medical histories and evaluations, including psychotherapy notes <input type="checkbox"/> Diagnostic and treatment progress and prognoses <input type="checkbox"/> Results of previous treatment <input type="checkbox"/> Information shared during initial team meeting and initial and all subsequent family meetings or case planning conferences <input type="checkbox"/> Abstract (includes face sheet, history and physical, consults, operative notes, emergency record, lab, radiology, ECG, reports, pathology, physical therapy and rehab) <input type="checkbox"/> Other: _____ _____	Timeframe: (If more than one timeframe is needed for information to be released, complete a separate PPS 0100)  <input type="checkbox"/> 2 years back with most recent test results <input type="checkbox"/> 4 years back with most recent test results <input type="checkbox"/> From birth <input type="checkbox"/> Other
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The purpose or reason for the release is: (Optional. If no purpose is stated, all lawful purposes are assumed)

_____ _____ _____
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Read before signing:

I understand that the information which I have authorized to be disclosed will be used for the purpose(s) stated. I acknowledge that it is my responsibility to be aware of any rights of confidentiality which I may have regarding the information which I am releasing and that by signing this consent I am waiving my rights, if any, to confidentiality for purposes which I have approved.

If I have authorized the release of information to a person or agency providing services under contract with DCF, I have also authorized release of the information to any person or agency providing that service under sub-contract.

This consent may be revoked in writing at any time prior to any action which has been taken in reliance upon it.

Unless otherwise revoked, this authorization will expire on the following date or event: \_\_\_\_\_

If I fail to specify an expiration date or event, this authorization will expire 180 days from the date signed.

Signature of person(s) giving consent: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

Relationship to person whose information is being released \_\_\_\_\_

