

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

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

☐ All Information necessary for DCF/CWCMP to provide services requested.	Timeframe: (If more than one timeframe is needed for information to be released, complete a separate PPS 0100) ☐ 2 years back with most recent test results ☐ 4 years back with most recent test results ☐ From birth ☐ Other
☐ All academic, achievement or aptitude evaluations and recommendations	
☐ Social, behavioral, psychological, mental or medical histories and evaluations, including psychotherapy notes	
☐ Diagnostic and treatment progress and prognoses	
☐ Results of previous treatment	
☐ Information shared during initial team meeting and initial and all subsequent family meetings or case planning conferences	
☐ Abstract (includes face sheet, history and physical, consults, operative notes, emergency record, lab, radiology, ECG, reports, pathology, physical therapy and rehab)	
☐ Other:	

The purpose or reason for the release is: (Optional. If no purpose is stated, all lawful purposes are assumed)

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 _____

