Child & Family Agency of Southeastern Connecticut, Inc.

# AUTHORIZATION FOR RELEASE OF INFORMATION

By filling out this form, you are agreeing to share information from another behavioral health or medical provider, school, individual or organization with Child and Family Agency of Southeastern CT, Inc. (CFA). This release grants permission for you to receive information to and from an individual or organization listed below.

**Whose Information is Being Released?**

First *: ______________________________ Last*: _______________________________________

Preferred Name (if any): _____________________________________________________________

Date of Birth*: _____/ _______/ _______ (MM/DD/YYYY)

What is your relationship to the client receiving services at CFA?*

- Self
- Parent
- Legal Guardian (other than the parent)
  - Define: __________________________________________
    __________________________________________

*If you are someone other than the client, please identify the client receiving services from CFA.*

First*: ________________________________ Last*: _______________________________________

Date of Birth*: _____/ _______/ _______ (MM/DD/YYYY)

**Individual or Organization Information**

Are you sharing information to an individual or a private or public organization? *

- Individual
- Private or Public Organization (i.e. school district, Department of Children & Families, hospital)

Individual that you are sharing information with

First*: _________________________________Last*: ________________________________________

Relationship with person receiving services: ________________________________________

Address Line 1: ___________________________________

Address Line 2 (PO Box, Apartment #, etc.): ________________________________

City*: _______________________ State*: ____________________ Zip Code: _____________

Phone Number: _____________________ Email Address: _______________________________

Additional Information (if needed): ____________________________________________________

_________________________________________________________________________________

Private or Public Organization

Name of Organization*: ________________________________________

Address: ________________________________________

City*: ____________________ State*: ________________ Zip Code: __________

Fax (Optional): ________________________ Phone Number: _____________________

Contact Person Information (physician, social worker, attorney):

________________________________________________________________________

Additional Information (if any)

________________________________________________________________________

________________________________________________________________________

**PHI Details***

Please select what information you would like to be released by marking the box next to the item (select all that apply)

- ☐ Psychiatric
- ☐ Medical
- ☐ Education
- ☐ Psychotherapy Summary Documents
- ☐ Other

  Define: ________________________

I specifically authorize release of the following sensitive information about my records or my dependent's records (select all that apply)

☐ Substance Abuse (alcohol/drug)

☐ Confidential HIV/AIDS-related information

**Acknowledgements**

By signing below, I understand and acknowledge the following:

- I understand this authorization will expire one year from the date signed, unless cancelled.
- This release does not authorize information received from third-party members to be shared.
- 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 CFA of the named recipient in writing. A revocation of this authorization will not apply to any records disclosed before the authorization is revoked. Pursuant to C.G.S. 17a-28(k) the information disclosed pursuant to this authorization is not subject to re-disclosure by the recipient without a separate authorization for that purpose except as provided by said statute.

Printed Name of person authorizing disclosure or authorized representative*

First ______________________________ Last ______________________________

Signature of person authorizing disclosure or authorized representative *

______________________________________ Date*: ___/ ___/ ______ (MM/DD/YYYY)