Advancing Individual & Community Health

Authorization for Release of Information (ROI) – Adolescent

Legal Name: _____ _____
(First) (Last)

Preferred Name (if any): _____

Date of Birth: _____ Phone: _____

Client Address: _____
(PO Box # or street, city, state, zip code)

You have received a copy of the Authorization of Release of Information that your parent/guardian has filled out. If you have not received a copy, please reach out to your clinician or a CFA employee to obtain one. The purpose of this document is to obtain your consent in releasing sensitive information, which could include:

Substance Abuse (which includes Alcohol and Drug Abuse)
Reproductive Health
Sexually Transmitted Disease
Or something else that has been indicated as sensitive

I understand that:

- This authorization is valid for one year from the date below. I understand that after I sign this form, I may cancel this authorization at any time by contacting CFA in writing.
- The parent or legal guardian must sign this authorization if the patient is a minor (under age 18) unless the records relate to treatment(s) for which the minor may provide consent under CT state law. If HIV, Drug/Alcohol information is included, the minor must sign as described above.
- Medical records containing protected information under applicable federal or state laws must also be authorized by a minor when age 13 or older (e.g. HIV, substance abuse including alcohol and drug abuse, reproductive health, and/or sexually transmitted disease).
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule. Pursuant to 45 CFR § 164.508, 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.

_____

Name of Adolescent Authorizing Disclosure Date

_____

Signature of Adolescent Authorizing Disclosure Date