Advancing Individual & Community Health

## Authorization for Release of Information (ROI)

Legal Name: _____ _____
(First) (Last)

Preferred Name (if any): _____

Date of Birth: _____Phone: _____

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

**I authorize Child & Family Agency of Southeastern CT, Inc. to release the following information: (select all that apply):**

- ☐ Complete Health Record
- ☐ Last History & Physical Exam
- ☐ Lab Results
- ☐ Immunization Record
- ☐ Medication List
- ☐ Mental Health Evaluations
- ☐ Progress Notes
- ☐ Summary of Treatment
- ☐ Other_____

**Sensitive Health Information**

**Check each box below to disclose the following:**

- ☐ Substance Abuse (which includes Alcohol and Drug Abuse)
- ☐ Reproductive Health
- ☐ Sexually Transmitted Disease
- ☐ Other _____

***Clients between 13-17 years of age must consent for the release of sensitive health information***. If you are a parent/guardian and any of the three top boxes are checked, a CFA representative will be reaching out to your adolescent for their consent and giving them a copy of this form.

**Information released for the purpose of ☐ care coordination**

**and/or ☐ other_____ to and from:**

Individual, Provider, agency or school district: _____Phone: _____

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

**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 Person Authorizing Disclosure or Authorized Representative Date

_____

Signature of Person Authorizing Disclosure or Authorized Representative Date

Please indicate relationship to the client:

| | |
|---|---|
| ☐ Self | ☐ Legal Guardian |
| ☐ Parent | ☐ Other Authorized Legal Representative: _____ |