Department of Children and Families

# AUTHORIZATION FOR THE RELEASE OF INFORMATION (*TO DCF*)

DCF-2131(T)
1/13 (Rev.)

I, _____ authorize

*(First and Last name of person granting permission)*

_____

*(First and Last name, address and telephone number of person, institution or organization in possession of the records / information)*

to disclose to the Department of Children and Families (DCF) and

_____

*(First and Last name, address and telephone number of DCF Staff receiving)*

The information / records pertaining to:

_____

*(First and Last name and DOB of person who is the subject of the record)*

Type of records to be released (check all that apply):

☐ Psychiatric ☐ Psychological ☐ Medical ☐ Education ☐ Medication

☐ Psycho-therapy notes *(NOTE: a request for psycho-therapy notes cannot be combined with a request for any other records).*

☐ Other (explain):

☐ I specifically authorize the release of the following sensitive information from my record:

*(Sign below for release of which type(s) of sensitive information you are granting)*

☐ Substance abuse (alcohol/drug) _____

☐ Confidential HIV/AIDS related information _____

☐ Sexually transmitted diseases _____

☐ Genetic testing

Purpose of authorization/disclosure:

The nature and extent of the information to be disclosed is the entire record unless otherwise specified below:

This authorization will expire in one year, if not cancelled _____

*Enter expiration date – one year from today*

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 DCF or 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.

_____ _____

*Signature of person authorizing disclosure or authorized representative* *Date*

Check boxes below if this form has been signed by a person other than the subject of the record:

☐ Parent/guardian ☐ Attorney ☐ Guardian ad litem ☐ Other (explain):

NOTE: Confidentiality of psychiatric, drug and/or alcohol abuse and HIV/AIDS records is required and no information from these specific records shall be transmitted to anyone else without written consent or authorization under Connecticut General Statutes, Chapters 899c and 368x and Federal Regulations 42 CFR 2. These laws prohibit the recipient of the record from making any further disclosure without specific written consent of the person to whom the record pertains. A general authorization for the release of this information is NOT sufficient for this purpose.