Connecticut Department of Children and Families
MULTI-DISCIPLINARY EVALUATION CHILD/YOUTH PERMISSION FOR RELEASE OF INFORMATION
DCF-460 MDE
8/2014 (New)

Instructions: Forward the original to the MDE Clinic and file a copy in the medical section of the Uniform Case Record.

Last Name Of Child:	First Name Of Child	Date Of Birth:	Link #:

As parent/legal guardian/designee of the Commissioner of Children and Families, I give medical permission and informed consent to conduct the MDE

Last Name:	First Name:	Title, if applicable:	Date:

Relationship To Child:	DCF Office & Address:
Please Select one	Please Select DCF Office
Name of Requesting DCF Social Worker:	DCF Social Worker's Phone Number:

MDE Clinic Name & Address:	Fax #:
Please Select One	

Authorization to Release Medical Information

The parent/legal guardian/designee of the Commissioner of the Connecticut Department of Children and Families authorize the above-named clinic to use and disclose the above-named child's protected health information gathered during the MDE, to obtain payment, and to carry out health care operations. The above named child/youth's protected health information may be disclosed to their health plan and/or its agents as necessary to verify benefits, authorize services, and process medical/dental claims. The protected health information may be disclosed to the Department of Children and Families, and other persons or health care providers or institutions involved in the MDE evaluation. The above named child/youth's protected health information may also be disclosed to outside agencies involved in his/her continuing care and/or for emergency care purposes. The child/youth's protected health information may also be disclosed to the child's primary care physician and other health care providers for continuing care. The child/youth's protected health information may include mental health and medical/dental information or any information pertaining to the examination, treatment, history, which may include Psychiatric, HIV/AIDS, infectious disease, alcohol and/or drug information, coded medical/dental information and charges to my health plan and/or their acting intermediaries and/or agents.

I understand that refusal to sign this authorization form will not affect my right to obtain present and future services from DCF, except where disclosure of the records requested is necessary for services. I also understand that I may revoke this authorization by notifying DCF in writing. A revocation of this authorization will not apply to any records disclosed before the authorization is revoked. The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by federal law.

For a child/youth between the ages of 13 and 17, no information pertaining to substance abuse or reproductive health may be released without a separate release of information signed by the child/youth (DCF-460-MDE-A).

The signature below indicates informed consent and medical permission to conduct the MDE and the release of medical information.

Last Name:	First Name:	Title, if applicable:

Signature:	Relationship To Patient:	Date: