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AUTHORIZATION TO DISCLOSE/EXCHANGE INFORMATION

Patient Name: ____________________ **Patient DOB: ________________________**

I, ______________________________(hereinafter "Client") hereby authorize The Therapeutic Center for Children and Families (hereinafter "Provider") to disclose / exchange mental health treatment information and records obtained in the course of treatment including, but not limited to, doctor or therapist's diagnosis to:

Name: ____

Address: ____

Telephone: ______________________ Fax: ____________________

The specific uses and limitations of the types of health information to be released are as follows (check all that apply):

- Treatment Coordination
- Treatment Planning
- Diagnostic Refinement
- Other: ____

Such disclosures shall be limited to the following types of information:

- Full Treatment Record (can include any or all of the information below)
- Psychiatric Diagnosis (es)
- Dates of Treatment
- Treatment Summary
- Treatment Plan
- Psychiatric Evaluation
- Psychotropic Medication Record
- Discharge Summary
- Psychological Testing
- School Reports
- Medical Reports
- Other: ____

This Consent to Disclose/Exchange Information expires on __________________or one year from the date of signature, whichever comes first.

__________ ______________________________ ____________________
Date Signature of Patient/Parent or Guardian Relationship to Child

__________ ______________________________
Date Signature of TCCF Provider

The Provider shall not condition treatment upon Client signing this authorization, and the Client has the right to refuse to sign this form. I understand that I may inspect and/or copy any information used/disclosed under this consent.

To the recipient of information related to psychiatric information: “The confidentiality of this record is required under Chapter 899 of the Connecticut General Statutes. This material shall not be transmitted to anyone without written consent or other authorization as provided in the aforementioned statutes.” A copy of the consent form setting forth any limitations shall accompany the disclosure.

To the recipient of information related to drug and/or alcohol treatment: “This information has been disclosed to you from records protected by federal and state confidentiality rules (2 C.F.R Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.” See Connecticut General Statue Section 17a-668.

The information to be obtained or disclosed was fully explained to me and consent was given of my own free will. I understand the medical record or clinical information to be released may contain information pertaining to psychiatric, drug and/or alcohol diagnoses and treatment. Any information related to drug and/or alcohol diagnoses and treatment is protected under Part 2 of the Title 42 of the C.F.R. I intend this consent to apply to such information. In addition, if any portion of the information to be obtained or released contains confidential HIV/AIDS related information, I expressly grant my authorization for release of that information as well.

I understand that if the person or the entity that receives the information is not a health care provider or health plan covered by the federal privacy regulations, the information described above may be redisclosed and therefore no longer protected by the federal privacy regulations.