Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_ State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE NOTE: THIS IS A LEGAL DOCUMENT AND WILL NOT BE HONORED UNLESS COMPLETED IN FULL**

I hereby authorize: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ of

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To release information to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ of

Covenant Family Services, LLC.

I hereby authorize Covenant Family Services, LLC. to release information to:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The information to be disclosed was explained to me and consent was given of my own free will. I understand the treatment record to be released may contain information pertaining to psychiatric, drug and/or alcohol diagnosis and treatment, or confidential (HIV) AIDS related information.

Specific Information to be released from my (or my child's) treatment record: (Check all that apply)

\_\_ Discharge Summary \_\_Treatment Plans \_\_ Consultations: written and/or verbal

\_\_ Psychiatric Evaluation \_\_ Medication Records \_\_ Communications

\_\_ Psychosocial Assessment \_\_ Laboratory Data \_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Psychological Testing \_\_ Medical History

\_\_ Limited to the following dates of service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The information for which I'm authorizing release will be used for the following purpose(s) and

All other use is prohibited:

\_\_ Pending legal action (copy charges will apply) \_\_ Disability / Social Security

\_\_ Personal use/self (copy charges will apply) \_\_ Worker Compensation

\_\_ Continuing care / follow-up care \_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand my treatment records are protected by the Health Insurance Portability and Accountability Act (HIPAA),

Federal Regulation (42 CFR, Part 2), and State of Connecticut General Statutes (Chapter 899, 52-146c). I understand

under applicable law the information disclosed under this authorization may be subject to further disclosure by the

recipient and thus, may no longer be protected by federal privacy regulations. I understand that my treatment or

continued treatment by Wellspring is in no way conditioned on whether or not I sign this authorization and that I may

refuse to sign it. I understand that I may revoke this consent at any time by written notification to the Clinical Director,

except to the extent that action has been taken. I understand that I may inspect or copy the information to be used or

disclosed. Minors receiving drug abuse treatment or treatment of venereal disease may sign their own authorization.

Unless otherwise revoked, this authorization will automatically expire one year from its signing.

Signature of Client or Legal Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| Information Released | By Whom | To Whom | Date |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |