Covenant Family Services, LLC.
580 Naugatuck Avenue
Milford, CT 06460
Phone: 203-446-1848
Fax: 203-283-7714

RELEASE OF PROTECTED HEALTH INFORMATION

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