

RELEASE OF PROTECTED HEALTH INFORMATION

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

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: _____
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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)

- | | | |
|--|---|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Treatment Plans | <input type="checkbox"/> Consultations: written and/or verbal |
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Medication Records | <input type="checkbox"/> Communications |
| <input type="checkbox"/> Psychosocial Assessment | <input type="checkbox"/> Laboratory Data | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Psychological Testing | <input type="checkbox"/> Medical History | |
| <input type="checkbox"/> 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:

- | | |
|---|---|
| <input type="checkbox"/> Pending legal action (copy charges will apply) | <input type="checkbox"/> Disability / Social Security |
| <input type="checkbox"/> Personal use/self (copy charges will apply) | <input type="checkbox"/> Worker Compensation |
| <input type="checkbox"/> Continuing care / follow-up care | <input type="checkbox"/> 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