DCF-2131(T)
Revised 3/2012

AUTHORIZATION FOR THE RELEASE OF INFORMATION TO THE DEPARTMENT OF CHILDREN AND FAMILIES

I authorize
(name of person granting permission)

(name and address of person, institution or organization in possession of records)

to disclose to the Department of Children and Families (DCF) and

(name, address and telephone number of DCF staff receiving the information)

Type of information/records to be released (**check all that apply**):

☐ Psychiatric ☐ Psychological ☐ Medical ☐ Education ☐ Medication

☐ Psycho-therapy notes (NOTE: a request for psycho-therapy notes cannot be combined with a request for any other records).

☐ Other (**specify**)

☐ I specifically authorize the release of the following sensitive information from my record
(initial all that apply):

_____ Substance abuse (alcohol/drug)	_____ Sexually transmitted diseases
_____ Confidential HIV/AIDS-related information	_____ Genetic testing

The purpose of this authorization/disclosure is to provide information to DCF for use in case planning, judicial proceedings related to child protection, development/implementation of an educational program or any other purpose for which this information can be lawfully used.

The nature and extent of the information to be disclosed is the entire record unless otherwise specified below:

This authorization, if not revoked, will expire on (Date) or in one year, whichever occurs first.

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.

_____
Signature of person giving permission or authorized representative Date

Check if this form has been signed by a person other than the subject of the record:

☐ parent/guardian ☐ attorney ☐ guardian ad litem ☐ other (**explain**)

NOTE: Confidentiality of psychiatric, drug and/or alcohol abuse and HIV/AIDS records is required and no information from these specific records shall be transmitted to anyone else without written consent or authorization under Connecticut General Statutes, Chapters 899c and 368x and Federal Regulations 42 CFR 2. These laws prohibit the recipient of the records from making any further disclosure without specific written consent of the person to whom the record pertains. A general authorization for the release of this information is NOT sufficient for this purpose.