



Client Name: _____

DOB: _____

Place Client Record Label here

Release of Information Authorization

This form must be filled out completely to be valid

I, _____, hereby authorize Stonington Institute to
 disclose information regarding myself to AND/OR obtain information regarding myself from

Name: _____

Address: _____

Phone: _____ **Fax:** _____

Client/Guardian please **INITIAL** the appropriate items:

How Information is to be Released:

____ Written Release ____ Verbal Release ____ Electronic Release

Type of Information to be Released: (cross through all non-applicable items)

____ Discharge Summary ____ Dates of Admission/ Discharge
____ Bio-Psychosocial Assessment ____ Diagnosis
____ Letter of Verification ____ Progress in Treatment
____ Nursing Assessment ____ Other: (Specify) _____

Purpose of Release of Information: _____

- This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will expire 30 days after discharge for current clients or 60 days from the date of signature for all others, or upon the following: (specific date, event or condition related to purpose of release) _____
- The confidentiality of this record is required under Chapter 899 of the Connecticut General Statutes as well as Title 42 of the United States Code. This material should not be transmitted to anyone without the client's written consent or authorization as provided for in these Statutes.
- I understand that the medical record to be released may contain information pertaining to psychiatric, drug, and/or alcohol abuse diagnosis and treatment, and may also contain confidential HIV (AIDS) related information.
- I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the client and thus may no longer be protected by federal privacy regulations.
- I understand that I may inspect or copy the information to be used or disclosed.

Client/Guardian Signature: _____ **Date:** _____

Client Date of Birth: _____ **Client SS#:** _____

Witness Signature: (For Clients Under 18) _____

Please send all correspondence to the attention of: _____ at

75 Swantown Hill Road, North Stonington, CT 06359

428 Long Hill Road, Groton, CT 06340

1353 Gold Star Highway, Groton, CT 06340

Questions? Please call 860-445-3000 and ask for the Health Information department.



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Suggested Timelines for Consent Expiration:

Purpose	Suggested date, event or condition upon which the consent will expire if not revoked before.
Communication with the legal system (i.e., courts, parole, probation)	30 days from discharge or 60 days from date of signature
Communication with after care treatment providers (medical, clinical, case management)	60 days from discharge or 90 days from date of signature
Communication with child welfare agencies	60 days from discharge or 90 days from date of signature
Communication with community supports (i.e., family, friends, religious/ spiritual supports)	10 days from discharge or 15 days from date of signature

Statement Regarding Confidential Information

Drug and Alcohol Abuse Records

In the event that information released is protected by the HHS confidentiality of Alcohol and Drug Abuse Patient Records regulations:

- This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosures 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 CFR 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 client.

HIV Related Information

In the event that information released constitutes confidential HIV related information protected under Connecticut law:

- This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Psychiatric Records and Communications

In the event that information released constitutes privileged psychiatrist/clinician-client communications:

- The confidentiality of this record is required under Chapter 899 of the Connecticut General Statutes. This material shall not be transmitted to anyone without the written authorization as provided in the aforementioned statutes.

All records are protected for confidentiality by Connecticut Statute Chapter 899, P.L. 93-579