Client Name: _____

DOB: _____

Place Client Record Label here

Stonington Institute

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:** _____

Purpose: ☐ **Aftercare** ☐ **Personal** ☐ **Legal** ☐ **Other:** _____

How Information is to be Released:

_____Written Release _____Verbal Release _____Electronic Release

Type of Information to be Released: (check all that apply)

_____Discharge Summary
_____Bio-Psychosocial Assessment
_____Letter of Verification of Treatment
_____Labs/PPD
_____Psychiatric Evaluation
_____Dates of Admission/ Discharge
_____Diagnosis
_____Progress in Treatment
_____Mental Status Examination
_____Psychological Evaluation

Other: (Specify) _____

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 one year from date** of signature unless otherwise specified: _____

- 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. *The confidentiality of this record is required under Chapter 899 P.L. 93-579 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.*
- A general authorization for the release of medical or other information is NOT sufficient for this purpose. Any information protected by Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2) is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure.
- 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.
- I understand that my current treatment or continued treatment by Stonington Institute is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it.

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

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

Mail or Fax to:

☐ 75 Swantown Hill Road, North Stonington, CT 06359 Fax: 860-535-9076
☐ 618 Poquonnock Road, Groton, CT 06340 Fax: 860-445-3030

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