CALISSA'S COUNSELING SERVICES

3580 Main St♦Building #11♦Suite E♦Hartford, CT 06120
Phone: (860) 778-5317♦ Fax: (860) 219-0100
www.calissascounseling.com

AUTHORIZATION FOR THE RELEASE OF INFORMATION

Please print all information

Client Name: _____ DOB: _____

I hereby authorize Calissa Welch, LCSW to: (check one or both):

☐ **Disclose** (share/send) information about my medical/services/educational records and me.
☐ **Obtain** (receive/request) information about my medical/service/educational records and me.

TO/FROM: Name and Address of third-party organization or individual

Name: _____ Phone: _____

Street Address: _____ Fax: _____

City: _____ State: _____ Zip Code: _____

The information that is obtained/disclosed might include my service, treatment and/or educational information related to my psychiatric diagnosis or treatment, substance abuse treatment, medical conditions, or my HIV-related information. The information may be obtained/disclosed in verbal, written and/or electronic format.

The PURPOSE of this disclosure is/are as follows: *(check all that apply)*

☒ Discharge planning or referral
☐ Educational/IEP Planning
☐ Court-related or legal
☐ Other: _____
☐ Disability determination or re-determination
☐ Treatment planning and/or coordination
☐ At request of individual (no statement of communication/ coordination purpose necessary)

Please describe any information that you'd like Calissa Welch, LCSW to NOT disclose about you: _____

_____

_____

I understand that:

- Under the applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus may not be protected by federal privacy regulations.
- I may revoke this authorization in writing at any time by contacting Calissa N. Welch, LCSW at 3580 Main Street, Hartford, CT 06120, except that it will not have any effect on actions taken by Calissa Welch, LCSW or the recipient organization before they received the written revocation/restriction request.
- I may receive a copy to inspect the information to be used or disclosed by this authorization.
- I may refuse to sing this form and that my refusal to sign this authorization will not jeopardize the right to obtain present or future treatment.

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- Confidential HIV-related information that may be disclosed includes whether the client has been counseled regarding HIV, has been the subject of an HIV test, or has HIV, HIV-related illness or AIDS, and also could include information pertaining to the client's spouse, sexual partner, or person with whom the client shared needles or syringes.
- **If the client is a minor (age 17 and under), any disclosure of drug and alcohol abuse records requires the consenting signature of the minor client below. Without such signature, Calissa N. Welch, LCSW will not disclose drug and alcohol abuse records or information to the third party named above.**

This authorization shall expire 30 days past discharge.

By signing below I acknowledge that I have read and understand this authorization. My signature below serves as attestation to the fact that I am the client, or I am the legal guardian of the child whose health information I am authorizing disclosure of.

_____ _____
Signature of client Date

_____ _____
Signature of parent/guardian Date

If signed by other than the client, print name _____ and check relationship:

☐ Parent ☐ Guardian ☐ Conservator ☐ Power of Attorney ☐ Other:_____

NOTICES

HIV/AIDS-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 further 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 or Therapist Records and Communications:
In the event that information released constituted privileged psychiatrist-patient, psychologist-patient, or therapist-patient communication: The confidentiality of this record is required under chapter 899 of the Connecticut General Statues. This material shall not be transmitted to anyone without written consent or other authorization as provided in the aforementioned statutes.

Drug and Alcohol Abuse Records:
In the event that information released is protected by the Federal Confidentiality of Alcohol and Drug Abuse Patient Records regulations: This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part2). The Federal rules prohibit you from making any further disclosure 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 C.F.R. 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 patient.