

AUTHORIZATION FOR DISCLOSURE OF INFORMATION

This form must be signed in order for the Department of Social Services (DSS) to disclose information (*including information about your health condition or treatment or payment for a health condition that DSS has in its records, also known as protected health information “PHI”*), if the use or disclosure is not directly related to running DSS’s programs or required by law or court order.

Subject of this Authorization (*name of DSS client*)

I authorize DSS to disclose the information indicated below to: (*name and address*)

for the following purpose(s):

(If you do not wish to state a purpose, you can write “at my request.”)

Type of Information DSS is Authorized to Disclose (*check those that apply*):

- medical* alcohol and/or drug treatment records** HIV related information*** financial
- employment history family and living situation DSS and other benefits currently or formerly received;
- records maintained by the Bureau of Rehabilitation Services (BRS) other _____

- I understand that my refusal to sign will not affect my ability to obtain services or benefits from DSS.
- I understand that I may revoke this authorization at any time by notifying DSS, in writing, except if a disclosure has already been made in reliance on it.
- I understand that the information I authorize a person or entity to receive may be redisclosed and no longer protected by privacy regulations.

This authorization expires on _____ or upon _____. (*If use or disclosure of PHI is for research purposes, including the creation and maintenance of a database, you can write “end of research study” or “none”.*)

Signature of Individual or Representative

ID # or S.S. # of Subject

Date

Printed Name of Person Who Signed

If a Representative, Authority to Act

Note to Recipient of Information:

- * The confidentiality of psychiatric records is required under chapter 899 of the Connecticut general statutes. This material shall not be transmitted to anyone without written consent or other authorization as provided in the aforementioned statutes.
- ** **Alcohol and/or Drug Treatment Records:** This information has been disclosed to you from records protected by Federal confidentiality rule (42 CFR Part 2). 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 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 patient.
- *** **HIV Related Information:** 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 state law. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose.

