

Community Counseling of Central Connecticut Inc.

53 Muir Ave Bristol, CT. 06010

860-582-7904

cccofcentralct.org

We treat people not privilege...

Release of information

Client Name: _____ **DOB/SS#** _____

I authorize Community Counseling of Central Connecticut Inc. (CCC) to:

Obtain From: **Release To:** _____

Check all that apply:

Biopsychosocial Assessment Case Management Clinical Assessment

Discharge Summary Lab Reports Psychological Eval

Medical Records Medical Notes Progress

Treatment Plan Other: _____

The following information from my client record will be used for the purpose of:

_____.

Dates of treatment covered by this release: **All** prior episodes of care.

Limited to the following dates/ programs: _____

Ongoing communication: I authorize reciprocal information exchange.

I understand that the records to be released may contain information pertaining to medical, sickle cell, psychiatric, drug including alcohol abuse treatment and or HIV/ AIDS related information.

- I agree that a copy of this authorization will be as valid as the original. I understand that I may revoke this authorization at any time, except to the extent that information has already been released.
- I understand that applicable federal and state law, the information disclosed under this authorization may be subject to further disclosure but the recipient and thus, may no longer be protected buy federal regulations.
- I understand that my current or future treatment by CCC is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign.
- The information to be obtained or disclosed was fully explained to me and this consent is given on my own free will.
- *This release will expire six months from the today's date _____ . This release will need to be renewed on _____ in order to remain in effect.*

Client signature

Date

Parent/Guardian/Conservator/ legal representative

Date

Witness signature

Date

(Ver 7-07)

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