Westbrook Youth and Family Services, Inc
P.O. Box 918, Westbrook, CT 06498
860-399-9239 Fax 860-399-7529

Consent & Authorization to Use, Disclose and Receive Mental Health Information

I, _____, _____ hereby authorize _____
Client Name DOB
_____
WYFS Clinician(s)

to release, request and/or exchange information and records obtained in the course of my diagnosis and treatment for the following purposes:

- Increase understanding of my previous history, diagnosis or treatment
- Coordinate care on an ongoing basis with other providers that are also treating me
- Discuss my care with friends or family that may be important sources of support
- Other (specify):_____

Information can be released to, requested from, or exchanged with the following:

Name of Individual/ Organization	*Address*	*Phone and Fax*

Please check:
This is a ONE-WAY release for WYFS to ___ RECEIVE or ____RELEASE records/information
_____ This is a TWO-WAY release

I understand the following:

1. This authorization will expire one year after I have signed this form, or on this date specified: _____
2. I may revoke this authorization at any time by notifying WYFS in writing and it will be effective on the date I notified except to the extent that action has already been taken in reliance on the authorization.
3. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by privacy regulations.
4. I am not required to sign this form to receive treatment or payment for my care.
5. There may be a fee for a copy of my records.
6. I understand that information to be released or obtained may include substance abuse treatment information in accordance with 42 CFR 2.1-2.67, and/ or HIV/AIDS related information in accordance with CGS 19a-585(a) except as indicated below:
   ____ No Substance Abuse treatment information ____ No HIV/AIDS

Signature: _____ Date: _____
(Client, Parent, or Legal Guardian
Print name: _____Relationship to Client: _____