the aurora house

Authorization for Release of Confidential Information

I, _____ - hereby authorize The Aurora Center to ***obtain*** the

following information from: _____

_____

_____

_____

I, _____- hereby authorize The Aurora Center to ***release*** the

following information to: _____

_____

_____

_____

I authorize and request the release of all pertinent information including:

_____ Academic

_____ Mental Health

_____ Substance Use

_____ Medical

_____ Insurance

_____ Legal

_____ Other _____

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 a specific written consent of the person whom it pertains, as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. PA 89-248

I understand that the confidentiality of the records requested may be required under Chapter 899 or 815 of the Connecticut General Statutes, may be protected under federal confidentiality regulations (42 CFR, Part 2) or may be protected under provisions of the law. I understand that if the requested information is confidential, it cannot be disclosed without my written consent unless otherwise provided in the statutes or regulations.

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

Specification of the date, event, or condition upon which this consent expires (unless I revoke consent earlier): **Upon Case Completion.** I further acknowledge that the information to be released was fully explained to me and that consent is given of my own free will.

_____ _____

Client Signature Date

_____ _____

Parent / Guardian Signature Date

Forward Information to: _____