CCGC
COMMUNITY CHILD GUIDANCE CLINIC

Locations
317 North Main Street and 1075 Tolland Turnpike
Manchester, CT 06042
860.643.2101 | www.ccgcinc.org

AUTHORIZATION FOR RELEASE/USE OF PROTECTED SCHOOL INFORMATION

Client Name: _____ DOB: _____

I, in behalf of myself, or as parent or guardian, authorize Community Child Guidance Clinic to **obtain from and/or release to** the following:

Name/Program: _____

Street Address: _____

City, State, Zip: _____

Phone: _____ Fax/Email: _____

Community Child Guidance Clinic cannot use or disclose certain information unless you specifically authorize such use or disclosure; this information will be restricted to those records dated from _____ to _____. **(Please Note – Each category must be marked under the correct individual column/s in order to obtain or release information.)**

OBTAIN FROM	RELEASE TO		OBTAIN FROM	RELEASE TO	
		Academic Records			Psychological Evaluations
		Classroom Notes & Information			School Social Work Reports
		Attendance Records			Social Behavioral Information
		Educational Testing			Special Education Records
		Guidance Counseling Records			Discipline/Incident Reports
		Health/Medical Records			Records and Communications
		Individual Educational Plans			Other Information (Please specify):
		504 Plans			

This information may be used only for the following purposes:

____Assessment & Treatment Planning ____Other Purpose (Please specify): _____

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Important information about this authorization:

- This authorization remains in effect for the duration of treatment, unless specifically withdrawn by the parent or guardian.
- In accordance with Community Child Guidance Clinic's Notice of Privacy Practices this authorization may be revoked by me at any time, with the exception of that information which has already been released, by providing a signed, written notice to Community Child Guidance Clinic.
- Treatment provided by Community Child Guidance Clinic is not conditional upon my signing this release and I may refuse to sign.
- The potential exists for the information to be subject to redisclosure by the recipient and no longer be protected by Connecticut or Federal law.

I am signing this authorization voluntarily.

Signature: Date:

(Please Check One) ☐ Parent ☐ Legal Guardian ☐ Client ☐ Other (Specify) _____

_____

(CCGC staff only) Witness Signature Date

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AUTHORIZATION FOR RELEASE/USE OF PROTECTED HEALTH INFORMATION

PLEASE READ

Any information released by Community Child Guidance Clinic is subject to the following stipulations:

- State of Connecticut law contained in Chapter 899 of the Connecticut General Statutes prohibits those receiving psychiatric information from making further disclosures of it or for using it for any purpose other than indicated on the release without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.

- Any information that is protected by the HHS Confidentiality of Alcohol and Drug Abuse Client Records Regulations (42CFR Part 2) prohibits you from making any further disclosures 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 release of medical or other information is not sufficient for this purpose. These rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

- In the event that information released constitutes confidential HIV-related information protected under Connecticut 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.