WYFS
Release of Medical Records

Please note that this is a legal document and will not be honored unless it is completed in full.

Client Name: ____
LAST FIRST MAIDEN or OTHER NAME

Date of Birth ____

Current Address ____

City/State/Zip ____

Phone (best number to reach) ____

I hereby authorize Westbrook Youth and Family Services

❑ to **release** information from my records to ❑ to **obtain** information from

Name ____

Address ____

City _____________________________________ State ___________ Zip ___________________

Phone ______________________________Fax _______________________________

RECORDS SHOULD BE ❑ Mailed ❑ Faxed ❑ Picked up in person

The following information is to be released/obtained

❑ Intake Summary/Assessment/Diagnosis
❑ Treatment Summary
❑ Treatment Plans, including goals
❑ Progress towards treatment goals
❑ Full Medical Records
❑ Other (must be specific):____________________

Pertaining to the period from: ________________ to ___________________

1. I understand that this authorization will expire one year after I have signed the form, or other time frame as specified: ____________
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that 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 understand that I am not required to sign this form in order to receive treatment or payment for my care.
5. I understand that there may be a fee for a copy of my medical record.
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

Authorized Signature: ____ Date: __________________________
(Client, parent, or legal guardian)

Please print name: ____Relationship to client: __________________

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Please return this request by FAX or mail to the attention of the CLINICAL DIRECTOR