AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Name:____ **Date of Birth:**______________

Address:____

I, the undersigned, hereby authorize the Wellspring Foundation, Inc. PO Box 370 Bethlehem CT 06751 Phone: 203-266-8000 Fax: 203-266-8030

✓ **To Release Information to:**	☐ **To Obtain Information from:**	
Name:	Agency: RECORDS DEPOSITION SERVICE, INC.	
Address: P.O. BOX 5054, SOUTHFIELD, MI 48086-5054		
Email: INFO@RECDEP.COM	Phone: 248-357-3330	Fax: 248-357-3337

the selected information from my (or my child's) treatment record: (please check)

✓ Discharge Summary	✓ Treatment Plans	✓ History & Physical
✓ Psychiatric Evaluation	✓ Medications	✓ Consultations
✓ Biopsychosocial Assessment	✓ Lab Data	✓ Verbal Communication
☐ Other:		

Purpose of this release of information: LEGAL - DISCOVERY BEFORE TRIAL

I understand that refusal to sign this authorization form will in no way affect my right to obtain present and future treatment, except where disclosure of such communications and records is necessary for treatment. I also understand that I may revoke this authorization at any time by written notification to this facility, except to the extent that action has been taken in reliance on it. I further understand that the confidentiality of psychiatric, substance abuse and HIV/AIDS records are protected under State and Federal laws and cannot be disclosed without my written authorization unless otherwise provided for by law. The information disclosed by this facility pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal law. I understand that this authorization is voluntary and that information to be released/obtained may include Medical, Psychiatric, Substance Abuse and/or HIV/AIDS treatment information unless otherwise specified above. I authorize electronic release of this information and have been provided with a copy of this form.

Date, event or condition upon which this consent expires: one year from its signing

____Date______________
Signature of Client: (required for all clients 13 or older)

____Date______________
Signature of Parent/Guardian/Legal Representative: (also required if client is under age 18)

Relationship to Client:

☐ Parent/Guardian	☐ Conservator	☐ Executor of Estate	☐ Power of Attorney

Note: Confidentiality of psychiatric, drug and/or alcohol abuse and HIV/AIDS records is required and no information from these specific records shall be transmitted to anyone else without written consent or authorization under Connecticut General Statutes, Chapters 899c and 368x and Federal Regulations 42 CFR 2. These laws prohibit the recipient of the records from making any further disclosure without specific written consent of the person to whom the record pertains. A general authorization for the release of this information is NOT sufficient for this purpose.