

**AUTHORIZATION FOR THE RELEASE OF SUBSTANCE USE TREATMENT COUNSELING NOTES TO DCF FOR CARE COORDINATION/CASE MANAGEMENT**

DCF-2131CNCC  
2/2026 (New)

I, \_\_\_\_\_ understand  
*(First and Last name of person granting permission)*

that my substance use disorder treatment counseling notes are protected under federal law, including 42 CFR Part 2 and HIPAA, and any applicable state laws. These notes can only be used or disclosed with my written consent, except as permitted by 42 CFR Part 2, HIPAA, and applicable state law.

I understand that I have the right not to sign this consent form. I understand that refusal will not affect my right to obtain present and future services, except where disclosure of the notes requested is necessary for services.

I authorize \_\_\_\_\_  
*(First and Last name, address and telephone number of person, institution or organization in possession of the counseling notes)*

to use and disclose to the Department of Children and Families (DCF) and/or the Assistant Attorney General as the Department's legal representative

\_\_\_\_\_  
*(First and Last name, address and telephone number of DCF Staff receiving)*  
my substance use disorder treatment counseling notes for care coordination/case management.

Unless I revoke my consent, this consent will take effect immediately and expire one year from today. I have the right to revoke this consent in writing at any time, except to the extent that action has been taken in reliance upon it. I understand that I may revoke this authorization by notifying DCF or the named recipient in writing.

I have been offered a copy of this form. It has been explained to me in a language I understand. I acknowledge that there is a potential for the notes used or disclosed pursuant to this consent to be subject to redisclosure by the recipient and no longer protected by federal law.

\_\_\_\_\_  
*Signature of patient*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature of other authorized person*

\_\_\_\_\_  
*Date*

Name of person signing, if other than patient:

Authority of person signing, if other than patient:  Parent/guardian  Attorney  Guardian ad litem  Other (explain):

**42 CFR PART 2 PROHIBITS UNAUTHORIZED USE OR DISCLOSURE OF THESE COUNSELING NOTES**