CONNECTICUT

Department of Children & Families

**AUTHORIZATION FOR THE RELEASE OF SUBSTANCE USE TREATMENT RECORDS TO DCF FOR LEGAL PROCEEDINGS**

DCF-2131TRLP

2/2026 (New)

I, _____ understand

*(First and Last name of person granting permission)*

that my substance use disorder treatment records are protected under federal law, including 42 CFR Part 2 and HIPAA, and any applicable state laws. These records 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 records requested is necessary for services.

I authorize _____

*(First and Last name, address and telephone number of person, institution or organization in possession of the records / information)*

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 records to be used in the criminal, civil, legislative, or administrative proceeding identified below

_____

*(Case Name or Number./Investigation Number if Known)*

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 records 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 RECORDS**

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