STATE OF CONNECTICUT – DEPARTMENT OF SOCIAL SERVICES

W-298
(Rev. 11/14)

AUTHORIZATION FOR DISCLOSURE OF INFORMATION

Name of DSS Client _____ **Client ID or S.S. #** _____

I authorize DSS to disclose the information indicated below to: (name and address of person to receive information)

_____

for the following purpose(s):

_____

(If you do not wish to state a purpose, you may write "at my request."

Type of Information DSS is Authorized to Disclose (check all that apply):

☐ PHI (other than mental health, substance abuse and HIV-related records) ☐ mental health records*****

☐ substance abuse treatment records****** ☐ HIV related information*******

☐ DSS application and documentation relating to benefits applied for, received or receiving

☐ other _____
(Please specify)

- I understand that my refusal to sign will not affect my ability to obtain services or benefits from DSS.
- I understand that I may revoke this authorization at any time by notifying DSS, in writing, except if a disclosure has already been made in reliance on it.
- I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by privacy regulations.

This authorization expires on _____ or upon _____. (If use or disclosure of
(Date) (Event)
PHI is for research, including the creation and maintenance of a database, write "end of research study" or "none.")

X_____ Date: _____
Signature of DSS Client or Person with Legal Authority to Sign for Client
(Attach copy of designation as Conservator/ Power of Attorney/ Guardian)

Printed Name of Person Who Signed _____

Note to Recipient of Information:

* The confidentiality of psychiatric records is required under chapter 899 of the Connecticut general statutes. This material shall not be transmitted to anyone without written consent or other authorization as provided in the aforementioned statutes.

**** Alcohol and/or Drug Treatment Records:** This information has been disclosed to you from records protected by Federal confidentiality rule (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure 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 the release of medical or other information is **NOT** sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

***** HIV Related Information:** This information has been disclosed to you from records whose confidentiality is protected by state 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 state law. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose.

Persons who are deaf or hard of hearing and have a TTD/TTY device can contact DSS at 1-800-842-4524.
Persons who are blind or visually impaired can contact DSS at 1-860-424-5040.