Clifford Beers Clinic
PERMISSION TO SHARE INFORMATION

SECTION A: Clifford Beers Clinic would like to share information about:

First Name	Middle Initial	Last Name	Date of Birth
Street Address			
City	State	Zip Code	Phone Number

SECTION B: Clifford Beers Clinic would like permission to give ☐ and get ☐ information from:

Agency	Contact Person		
Street Address			
City	State	Zip Code	Phone Number

SECTION C: The kind of information we want to share is checked off below.
Please put your initials next to the checked boxes to agree with sharing this information. If you don't put your initials next to the box, we won't share that information.

Documents	YES	Guardian Initials	Client Initials	Documents	YES	Guardian Initials	Client Initials
Admission Summary	☐			Neurological Evaluation	☐		
Discharge Summary	☐			Laboratory Data	☐		
Treatment Plan	☐			Educational Evaluations	☐		
90 Day Reviews / Transfer Summaries	☐			School Adjustment	☐		
				Speech/Hearing/Language Evaluations	☐		
Psychological Report	☐			Court/Correction Record	☐		
Psychiatric Evaluation	☐			Other:	☐		
Medical Reports	☐						

SECTION D: We need special permission to share certain kinds of information.
Please put your initials next to the checked box to agree with sharing this of information. If you don't put your initials next to the box, we won't share that information.

Documents	YES	Guardian Initials	Client Initials
Drug Abuse/Alcohol Related Information: This information is protected by Federal Confidentiality Rules (42 F.C.R. Part 2). It may not be shared with anyone else unless written consent from the person in Section A is given.	☐		
HIV/AIDS Information: This information is protected by Federal Statute (Conn. Gen. Stats. § 19a-581(9)). It may not be shared with anyone else unless written consent from the person in Section A is given.	☐		

SECTION E: Clifford Beers Clinic is sharing this information because:

☐ The Client or Guardian asked for it ☐ It may help with treatment ☐ Other:

SECTION F: The Connecticut General Statutes give this information about your rights

- It is required that your record is confidential (Chapter 889)
- The information in your record will not be shared without written permission (52-146 CGS)
- You may take back this authorization at any time, unless action has already been taken
- This authorization expires 1 year from the date you sign it.

SECTION G: Signatures By signing below, I give permission for the Protected Health Information listed in Sections "C" & "D" about the person in Section "A" to be shared.

Signature of Client	**Date**	
Signature of Guardian	**Date**	**Relationship to the person in Section "A"**
Staff Signature	**Date**	

ROI form FINAL 5/12

Revised 06/10/2019