345 North Main St., Suite 306
West Hartford, CT 06117
860-233-8803

RELEASE OF MEDICAL INFORMATION TO THE NEXT RIGHT THING, LLC

I, the undersigned, hereby authorize _____ to release any medical information including Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS) status and/or condition, and/or psychiatric information, and/or drug and alcohol information, if applicable, from my own or my child's medical record for the purpose of _____ to The Next Right Thing, LLC.

(A photocopy of this form shall be as valid as the original)

The confidentiality of psychiatric records is required under the Connecticut General Statutes. This information shall not be transmitted to anyone without the written consent or authorization as provided in Connecticut General Statutes. Section 51-146. I may revoke this authorization at any time except to the extent that action has been taken thereon. This authorization, unless expressly revoked earlier, expires 365 days from the date signed. PL 93-282.

_____ _____

Signature (Patient, parent, or legal guardian) Date