Marguerite Ruppenicker, Ph. D.

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Release of Information for Records and/or Professional Communication

Please note that this is a legal document and will not be honored unless it is completed in full.

Client Name:_____ D.O.B.:_____Date:_____
I authorize Marguerite Ruppenicker, Ph. D. to RECEIVE ☐ RELEASE ☐ the following information regarding my /my child's:(Indicate as many as apply, Client or Guardian must initial each section)

Initials		Initials	
_____	☐ Intake Summary/Assessment	_____	☐ Medication History
_____	☐ Psychiatric Evaluation/Report	_____	☐ Treatment Plan(s)
_____	☐ Alcohol/Drug Use Evaluation Report	_____	☐ Discharge Summary
_____	☐ Educational History/Status	_____	☐ Medical Records
_____	☐ Psychological Evaluation/Testing Report	_____	☐ Progress towards therapy goals
_____	☐ Other (must be specific):_____		

FROM ☐ OR TO ☐(agency/individual):_____

_____

_____

Address of Agency/Individual/Hospital/School/Facility _____

_____

PHONE: _____ FAX: _____

Pertaining to the period from:_____to:_____

For the purpose of: Mental health evaluation, or care ☐;Treatment planning ☐;Other:_____ _____☐

----------**Permission for Professional Communication**----------

(*please check only one)* This is a ☐ one-way release of information ☐ two-way release of information

I give permission for the above named individual(s) to verbally communicate with my therapist Marguerite Ruppenicker, Ph. D.

This authorization will remain in force until (*choose one*) ☐ One year, or conclusion of treatment
☐ 60 days from date below; ☐ Other (specify):_____

I understand that I may withdraw this consent at any time prior to the release of the above information and understand that withdrawal of this authorization must be made in writing to Marguerite Ruppenicker, Ph.D. I understand that the refusal to grant consent will not jeopardize my right to obtain present or future treatment except where disclosure of the communications and records is necessary for treatment.

_____ _____
Client's Signature Date

_____ _____
Parent/Guardian's Signature Date

_____ _____
Witness's Signature Date

If the client is an adult and does not sign the above consent the person who does sign must prove, with written documentation, their authority to do so.

Information regarding alcohol and drug abuse records which are released by Marguerite Ruppenicker, Ph. D. is protected by Federal Confidentiality Regulation CFR Part 2. This prohibits you from making any further disclosure of this information. In the event that you receive a request for any or all of the enclosed information, that request must be referred to Marguerite Ruppenicker, Ph. D.

STATEMENT REGARDING CONFIDENTIAL INFORMATION

Psychiatric Records and Communications:

In the event that information released constitutes privileged psychiatrist-patient communications:

> The confidentiality of this record is required under Chapter 899, Section 52-1461 of the Connecticut General Statues as well as Title 42 of the United States Code. This material shall not be transmitted to anyone without written consent or authorization as provided in (these) statues.

Drug and Alcohol Abuse Records:

In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records regulations:

> This information has been disclosed to you from records protected by Federal Confidentiality rules (42 CFR Part2). The Federal rules prohibit you from making any further disclosures of this information unless further disclosure is expressly permitted by 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 prosecute any alcohol or drug abuse patient.

HIV Related Information:

In the event that information released constitutes confidential HIV related information protected under Connecticut law.

> This information has been disclosed to you from records whose confidentially 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 said law. A general authorization of medical or other information is NOT sufficient for this purpose.