women&familylife CENTER
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Agency Referral Form

Women & Family Life Center provides services to women and all families, regardless of income, from any of the following 15 towns that we serve: Branford, Chester, Clinton, Deep River, Durham, East Haven, Essex, Guilford, Killingworth, Madison, Middlefield, North Branford, North Haven, Old Saybrook and Westbrook.

Please complete form in its entirety along with ROI for referring party and any relevant parties. Documents may be faxed to (203) 458-0616 or emailed to: info@womenandfamilylife.org. Please allow 2 business days for follow up. Participants will need to complete an intake with W&FLC staff. Any questions please call (203) 458-6699 and ask to speak to a Referral Navigator or Program Manager.

Referring Agency Information

Referring agency:_____ Date: _____

Worker Name: _____ Title: _____

Phone Number: _____ Email: _____

Requested Assistance Details

(Circle or highlight all that apply)

- Divorce/Custody (Legal, Group)
- Domestic Violence or Sexual Assault
- Financial Education
- Legal Services (Non-Divorce)
- Support Group (Non-Divorce)
- Other (specify):

Referred Participant Information

Name:_____ Date of Birth: _____

Address: _____ Phone Number: _____

Email: _____ Is it safe to leave a voicemail? Yes or No

Other Details about Participant

Please call, email, or visit our website for more information. Phone: 203-458-6699; website: https://womenandfamilylife.org/; email: info@womenandfamilylife.org

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Authorization For Release of Information

Today's Date: _____

Participant Name: _____
First Middle Last

Date of Birth: _____

I hereby authorize Women & Family Life Center to (check): ____ obtain information ____ release information

Name/Organization: _____

Address: _____

City: _____ State: _____Zip Code: _____

Phone: _____

Email: _____

The information to be released includes:_____

_____

This information is to be released for the purpose of: _____

_____

The designated information about me ( ) may or ( ) may not be transmitted by fax, electronic mail, or other electronic file transfer mechanisms.

The provider of the information and the recipient designated above ( ) may or ( ) may not discuss by telephone the content of the information released.

I understand that my Authorization will remain effective for one year from the date of my signature unless otherwise specified. Specific date for termination of Authorization: _____

I understand that I may specify information not to be shared via this Authorization. Please exclude: ____

_____

_____

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I specifically consent to the disclosure of information concerning drug/alcohol abuse records ____(initial here)

I specifically consent to the disclosure of information concerning HIV/AIDS status _____ (initial here)

I understand that I may revoke the Authorization at any time by written, dated communication, except to the extent that the person instructed to make disclosure has already taken action to do so.

I understand that W&FL may not refuse services if I choose not to sign this or any other Authorization.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

I have read and understand the nature of this Authorization.

Participant Signature:_____ Date:_____
(Parent or guardian if under 18)

Staff Witness Signature:_____ Date:_____

Your signature allows a photocopy or fax copy of this authorization to be as valid as the original.

Relevant Connecticut and Federal Statutes:

The recipient of the requested information is prohibited by federal law (Code of Federal Regulations 42, Part 2) from making any further disclosure of it without the client's written permission.

The confidentiality of this record is required under Chapter 899, PL 93-079 of the Connecticut General Statutes. This material shall not be transmitted to anyone without written authorization as provided in the aforementioned statutes.

Drug and Alcohol Abuse Records: In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Regulations: This information has been disclosed from records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Rules prohibit you from making any 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.

Confidential HIV Related Information: In the event that information to be released would disclose a person's HIV status: 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 said law. A general authorization of medical or other information is not sufficient for this purpose (Connecticut General Statutes, 19a-581 through 19a-593).

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