AUTHORIZATION FOR INFORMATION

JD-CL-46 Rev. 7-12
C.G.S. §§ 10-154a, 17a-693, 17a-694, 31-128f, 52-146b to 52-146o

(See Instructions and "Notice to Receiver of Information" on back/page 2)

STATE OF CONNECTICUT
SUPERIOR COURT
www.jud.ct.gov

1.
From *(Full name of person giving permission to give information or asking for information)*

Information needed by *(Date)*

Address

2.
I give the Judicial Branch permission
☐ to **GET** the information in section 4 from: ➡ *(Fill out the name and address boxes)*
☐ to **GIVE** the information in section 4 to: ➡ *(Fill out the name and address boxes)*

Name

Address

3. Information About:

Name *(Full name of Subject of Record)*

Date of birth

☐ *(Check if authorization is for information concerning a minor child)*

4. Type Of Information:

Instructions: The person completing this authorization should be advised that this form may not be used to give both psychotherapy notes and other types of health information. If this form is being used to give psychotherapy notes, a separate form must be used to give any other health information. Authorizations to give sensitive health information (such as HIV/AIDS or substance abuse) should be initialed by the requestor. ("x" all that apply):

☐ Entire Medical Record
☐ Only information related to *(specific diagnosis, injury, operation, etc.)* _____
☐ Only the period of events from _____ to _____
☐ Billing Records
☐ Psychotherapy Notes **ONLY*** *(by checking this box I am waiving any psychotherapist-patient privilege)*
☐ School Transcript
☐ Other: _____

☐ I specifically give permission to give the following sensitive information from my health record. *(Initial all that apply)*
_____ Substance Abuse *(Alcohol/Drug)*
_____ Confidential HIV/AIDS Related Information
_____ Mental Health *(Other than psychotherapy notes)*
_____ Sexually Transmitted Disease
_____ Genetic Testing

** PSYCHOTHERAPY NOTES means notes recorded (in any form or medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of an individual's medical record.*

5. Purpose Of Authorization if this Authorizes the Judicial Branch to Get Information:

This request is being made at the request of the individual for purposes related to the case identified in this section which may include, but not be limited to, court ordered investigation or evaluation, supervision and mediation or negotiation:

Court
☐ Judicial District ☐ Geographical Area Number _____ ☐ Juvenile Matters

At *(Town)*

Docket number

If Supervision, show type and duration

6. If this Authorizes the Judicial Branch to Get Information, please send it to:

Judicial Branch Division

Name of person requesting information

Telephone number

Office or court mailing address

7. Purpose Of Authorization if this Authorizes the Judicial Branch to Give Information: (Specify) _____

8. Statement of Authorization *(See explanation on page 2)*

I ask and give permission to the person or institution named above to release to the Recipient specified above copies of the information requested in Sections 3 and 4 of this form and I give permission to the Recipient to release that information, whether obtained by this or an additional authorization required by the person or institution named in Section 2, by making it available for inspection, including any sensitive information identified in Section 4, to the Court, to parties to the case, to attorneys in this case, and to any appointed Guardian Ad Litem. These recipients must not further disclose this information except that non-sensitive health information may be disclosed for legitimate trial and trial preparation purposes related to this case. I have read this form/had this form read to me and I understand the purpose of this release of information. I understand that signing this is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned on my authorization for this disclosure. I understand that I may inspect or have copies made of the information to be used or disclosed (excluding psychotherapy notes). I understand that under applicable law, the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations. I understand that I may revoke this authorization, in writing, at any time by sending such written notification to the person or institution named above, except to the extent that action has already been taken in reliance on it; or, except in the case of disclosure to those persons within the criminal justice system who have made my participation in a program or service provided by the person or institution named above a condition of (1) the disposition of any criminal proceedings against me, (2) my release from custody or (3) my probation. My permission, unless expressly revoked earlier, automatically expires as stated below.

Give date, event or condition on which your permission ends, which can be no later than the final disposition of your case

Signature or person giving permission *(If minor, signature of parent or guardian, unless Section 19a-592 of the Connecticut General Statutes applies)*

Date signed

Signature of Witness

If signed by a legal representative, check relationship to subject of record and provide written proof of your authority *(Parents do not need documentation):*
☐ Parent ☐ Guardian ☐ Conservator ☐ Executor of Estate ☐ Power of Attorney

DISTRIBUTION: ORIGINAL - Party holding requested information COPY 1 - C.S.S.D. Office or Court File COPY 2 - Authorizing individual

Instructions to Judicial Branch Staff Asking for Permission to Get Information

1. Fill out sections 1, 3, 4, 5 and 6.
2. In section 2, check the "GET" information box and enter the name and address of the hospital, school, physicians, clinic, laboratory, pharmacy, insurer or other health care provider that has the information.
3. Have the person whose information is being asked for fill out section 8 and have them sign the form in front of a witness.
4. Give a copy of the form to the person giving permission.

Instructions to Person Asking the Judicial Branch for Information

1. Fill out section 1.
2. In section 2, check the "GIVE" information box and enter your name and the address where the information is to be sent.
3. Fill out sections 3, 4 and 7.
4. Have the person whose information is being asked for fill out section 8 and have them sign the form in front of a witness.
5. Keep a copy for your records.

Notice To Receiver Of Information

Federal and state law prohibit making any further disclosure of alcohol and/or drug abuse information (42 CFR Part 2), educational records for a minor obtained under 34 CFR Part 99 (Family Educational Rights and Privacy Act (FERPA)), HIV-related information (Chapter 368x of the Connecticut General Statutes), psychiatric or other mental health information (Chapter 899 of the Connecticut General Statutes), without specific written authorization. If the disclosure contains information relating to HIV-related information, alcohol or drug abuse information, the following notice applies:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2) or state law. The Federal rules or state law 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 said law. 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.

Explanation of Statement of Authorization

In Section 8 of this form, if you sign this form:

- You give permission to give this information and if it is for use in a court case, this information, including any sensitive information checked in Section 4, may be looked at by the Court by the parties to the case, by attorneys in this case, and by any appointed Guardian Ad Litem. They must not give this information to anyone else except they can give out non-sensitive health information for legitimate trial and trial preparation purposes having to do with this case.
- You are saying that you have read this form or have had it read to you and that you understand it. You understand that signing the form is your own decision.
- You understand that, except for psychotherapy notes, you may look at or have copies made of this information.
- You understand that the information given by this authorization may not be protected by federal privacy regulations.
- You understand that you may take back your permission at any time by writing to the people or places in Section 2 on this form but you understand that you cannot take back your permission if they have already taken action on it; or, if the information has been given to people in the criminal justice system who have made your participation in a program or service provided by the person or place in Section 2 a condition of (1) resolving your case (2) your release or (3) your probation.
- Unless you take it back earlier, your permission ends on the date you say on the form in the box below the Authorization.

If you do not sign this form your healthcare benefits and any healthcare cannot be taken away.

ADA NOTICE

The Judicial Branch of the State of Connecticut complies with the Americans with Disabilities Act (ADA). If you need a reasonable accommodation in accordance with the ADA, contact a court clerk or an ADA contact person listed at *www.jud.ct.gov/ADA.*