



STATE OF CONNECTICUT
DEPARTMENT OF CHILDREN AND FAMILIES



**Multi-Disciplinary Evaluation
Child/Youth Permission for Release of Information**

Instructions Please have child/youth ages 13 to 17 read and sign granting permission for release of information.

Date: _____

I, _____ give permission for
Name of Child/Youth Granting Permission

Provider/Clinic Name

Provider/Clinic Address

to disclose to the Department of Children and Families any information learned from my Multi-Disciplinary Evaluation about substance abuse (alcohol/drug use and treatment) and reproductive health (sexual activity, sexually transmitted diseases and birth control) information.

During my evaluation, some questions may be asked about my alcohol and drug use and treatment and reproductive health. I understand this information will be shared with DCF, including the social workers. They will keep this personal information confidential and will not share it with anyone else unless given permission by me or my lawyer, or unless ordered by a judge. The purpose of this authorization/disclosure is to provide information to DCF for use in case planning.

I understand that refusal to sign this authorization form will not affect my right to obtain present and future services from DCF, except where disclosure of the records requested is necessary for services.

If I change my mind about this authorization, I understand it will not apply to any information already disclosed. I also understand the information that is disclosed to DCF may be re-disclosed according to federal law.

Printed Name of Child/Youth Granting Permission

Signature of Child/Youth Granting Permission

Date