

**AUTHORIZATION FOR RELEASE
OF CONFIDENTIAL HEALTH CARE INFORMATION**

Patient Name:		Date of Birth:	
Street Address:			
City	State	Zip	

This authorizes _____ to request and receive
Prescriber's Name

from the Connecticut Department of Consumer Protection any and all records held by the Department relating to Schedule II-V controlled substances dispensed to the patient named above.

I understand that this authorization permits the Department of Consumer Protection to disclose confidential health care records to the prescriber named above. A copy of this authorization shall be included with my original records. There is a potential for any information disclosed pursuant to this authorization to be subject to re-disclosure as permitted or required by law.

I understand that, if not previously revoked, this consent will expire one year after the date of my signature unless otherwise specified.

Patient Signature:	Date:
Guardian Signature:	Date:

NOTE: This authorization form is in addition to and separate from any other disclosure forms that you may have signed.