CENTER FOR CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS
REGIONAL MEDICAL HOME SUPPORT CENTER
REGION 5

RELEASE OF INFORMATION

I/We the undersigned hereby authorize any and all physicians, medical providers, medical facilities, therapists, schools, early intervention services, medical insurance companies and any other person or agency involved in my child's health and/or education needs to communicate with and/or release information to:

REGIONAL MEDICAL HOME SUPPORT CENTER
St. Mary's Hospital- Children's Health Center
56 Franklin St.
Waterbury, CT. 06706
Tel:(203) 709-5716 or Toll Free: (866) 517-4388 Fax: (203) 709-5153

For the purpose of evaluation and/or care coordination.

CHILD'S NAME:________________________DATE OF BIRTH_______

SIGNED:_________________________________DATE______________
Parent/Guardian

SIGNED:_________________________________DATE______________
Parent/Guardian

The confidentiality of this record is required under Chapter 899 of the Connecticut General Statutes. This material shall not be transmitted to anyone without written consent or other authorization as provided in the aforementioned statutes.

I may revoke this authorization at any time, except to the extent that action has been taken in reliance thereon. This authorization, unless expressly revoked earlier, expires one year from date signed.
Release.doc 3/06