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AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned patient or legal representative, hereby authorize _____ to disclose or obtain health information, *including if applicable*, information relating to the diagnosis or treatment of mental illness, drug and/or alcohol abuse and confidential HIV related information regarding:

Patient Name:_____ Birth date: ____/____/____ Phone: _____

Information may be ☐ Disclosed to
☐ Obtained from Other Facility

Name/Facility:_____

Mailing Address: _____

City/State/Zip _____

Phone #: (_____)_____

☐ Hand-Carry ☐ Fax to: _____

2. The purpose of this disclosure or use is for the following reason:

☐ Medical ☐ Legal ☐ Disability ☐ Insurance

☐ At the request of the patient or legal representative

☐ Other (please specify) _____

3. The dates of service and the type(s) of information to be used or disclosed is as follows:

Date(s) of Service:_____

☐ Inpatient ☐ Outpatient ☐ Emergency Visit

4. Requested Information:

☐ **Complete Record** ☐ Abstract Only

Please specify if you need specific reports only:

☐ History & Physical ☐ Laboratory Report
☐ Discharge Summary ☐ X-Ray Report
☐ Operative Reports ☐ EKG Report
☐ Consultations ☐ X-Ray Films (Radiology Dept.)
☐ Billing Statement (Patient Accounts Dept.)
☐ Other (please specify) _____

I understand that my treatment or continued treatment by _____ is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it. 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 inspect or request a copy of the information to be used or disclosed by the recipient.

This authorization will be valid for a period of one year from the signature date below. Medical records will only be released for dates of service which occur prior to the authorization date unless disclosure of a future service date is specifically authorized. I understand that I may cancel this authorization at any time by notifying _____in writing, but if I do it will not have any effect on actions that the release took before it received the cancellation.

Copy Fees: I understand that _____ may charge a fee for copying and first class postage to the individual receiving the requested information. Copy fees will be applied in accordance with Connecticut Statute at $0.65 cents per page.

_____ _____ _____
Signature of Patient or Legal Representative **Date** **Printed Name**

If not patient, state the relationship to patient below (legal documentation required as applicable):

☐ Parent ☐ Guardian ☐ Conservator ☐ Executor of Estate ☐ Power of Attorney ☐ Other: _____

NOTE: The confidentiality of psychiatric, alcohol, drug and HIV related records is required by Connecticut General Statutes and/or Federal Regulations 42 CFR, part 2. This information shall not be re-disclosed to anyone else without written consent or other authorization as provided in the Connecticut General Statutes and/or Federal Regulation 42 CFR, part 2. A general authorization for the release of medical information is not sufficient for this purpose.