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AUTHORIZATION FOR THE RELEASE OF INFORMATION

Please PRINT all information

PATIENT NAME (LAST, FIRST)	DATE OF BIRTH	PATIENT ID# (OPTIONAL)

I HEREBY AUTHORIZE ____TO RELEASE
(PHYSICIAN/PROVIDER)

INFORMATION TO:

PERSON/FACILITY/AGENCY:____

STREET ADDRESS:____

CITY, STATE, ZIP:____

PHONE:__________________________________ FAX:__________________________________

PURPOSE OR NEED FOR INFORMATION REQUESTED:____

TYPE OF RECORD:_______OFFICE MEDICAL_______IN/OUT PATIENT_______OTHER

THE MEDICAL RECORDS ARE DATED:________________________TO________________________

THE FOLLOWING INFORMATION MAY BE RELEASED: (INITIAL EACH TYPE TO BE RELEASED)

_______MEDICAL/SURGICAL _______LABORATORY/PATHOLOGY _______MEDICAL IMAGING _______OTHER

_______DRU&ALCOHOL ABUSE _______MENTAL HEALTH/PSYCHIATRIC (excluding Psychotherapy notes)

MENTAL HEALTH RECORDS -- In the event that information released constitutes privileged mental health patient communications, 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 authorization as provided in the aforementioned statutes.

DRUG & ALCOHOL ABUSE RECORDS -- In the event that information release is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Record regulations: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of the information unless further disclosure of authorization for 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.

AIDS OR HIV RELATED INFORMATION -- This information has been disclosed to you from records protected by State Law. Connecticut State LAw prohibits you from making any further disclosure without the written consent of the patient or as otherwise permitted by said law.

I UNDERSTAND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY TREATMENT OR PAYMENT. FURTHERMORE, I UNDERSTAND THAT ONCE INFORMATION HAS BEEN DISCLOSED SUBJECT TO THIS AUTHORIZATION, THE INFORMATION MAY BE SUBJECT TO REDISCLOSURE AND NO LONGER PROTECTED BY STATE OR FEDERAL LAW.

PATIENT SIGNATURE*____DATE:____________________

_________ The PATIENT has NOT SIGNED this form, please indicate the relationship of the signator to the patient

_____Parent/Guardian_____Administrator/Executor of Estate_____Power of Attorney/Conservator_____Other/Specify:_______________________

SIGNATURE OF REQUESTOR:__________________________ DATE:______________ WITNESS:__________________

PRINT NAME OF REQUESTOR:__________________________PHONE NUMBER:__________________________

THIS AUTHORIZATION MAY BE REVOKED IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT INFORMATION HAS BEEN OBTAINED OR RELEASED. YOUR RIGHTS TO REVOCATION MAY BE FOUND IN THE NOTICE OF PRIVACY PRACTICES. THIS AUTHORIZATION SHALL EXPIRE 12 MONTHS FROM THE DATE OF SIGNATURE OR UPON THE FOLLOWING EARLIER EVENT, CONDITION OR DATE:____