



104507

MR#: _____
 Date Completed: _____
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 Initials: _____

AUTHORIZATION TO DISCLOSE/OBTAIN HEALTH INFORMATION

Subject to the statements printed on the back, I, the undersigned patient or legal representative, hereby authorize the use and disclosure of health information including, if applicable, information relating to the diagnosis or treatment of mental illness, drug and/or alcohol abuse and HIV related information.

Patient Name: _____

Date of Birth: _____

FILL OUT FOR INSTITUTE OF LIVING TO DISCLOSE	FILL OUT FOR INSTITUTE OF LIVING TO OBTAIN
I authorize the Institute of Living to disclose health information to: Name: _____ Facility: _____ Address: _____ Tele#: _____ Fax#: _____	I authorize _____ To disclose health information to department: Institute of Living 80 Seymour Street P.O. Box 5037 Hartford, CT 06102-5037 Contact Person: _____ Tele#: _____ Fax: _____
Method of Disclosure: <input type="checkbox"/> Mail <input type="checkbox"/> Verbal <input type="checkbox"/> Pick-up <input type="checkbox"/> Review	
The dates of service and the type(s) of information to be used or disclosed are as follows:	
Date(s) of Treatment: _____	
<input type="checkbox"/> History & Physical <input type="checkbox"/> Discharge Summary <input type="checkbox"/> ED Record <input type="checkbox"/> Psychiatric Intake & Eval <input type="checkbox"/> Consultations <input type="checkbox"/> Laboratory Reports <input type="checkbox"/> Radiology Reports <input type="checkbox"/> EKG/EEG Reports <input type="checkbox"/> Psych/Neuro testing <input type="checkbox"/> Psychosocial Assess. <input type="checkbox"/> Progress Reports/TPR <input type="checkbox"/> Billing Records <input type="checkbox"/> Entire Record <input type="checkbox"/> Other	
The purpose of this disclosure or use is for the following reason:	
<input type="checkbox"/> Medical <input type="checkbox"/> Legal <input type="checkbox"/> Disability <input type="checkbox"/> Insurance <input type="checkbox"/> At the request of the patient <input type="checkbox"/> Other _____	

- This authorization will be valid for a period of one year from the date below. I understand that I may revoke this authorization at any time by notifying Patient Relations in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- 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 my treatment or continued treatment by the Institute of Living is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it.
- I understand that I may inspect or copy the information to be used or disclosed. I understand there is a charge for copies.
- The parent of legal guardian must sign this authorization if the patient is a minor (under age 16) or has a legal guardian.
- Minors receiving drug abuse treatment or treatment of venereal disease may sign their own authorization.

Authorization can be sent to: **Health Information Management
80 Seymour Street Bliss 139
Hartford, CT 06102-5037**

Signature of Patient or Legal Representative

Date

Time

Relationship to patient: Self Parent Guardian

Witness

Conservator Executor of Estate Power of Attorney Other _____

If signed by the legal Representative attach appropriate documentation to verify authority



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HIV RELATED INFORMATION

In the event that information release constitutes confidential HIV related information protected under Connecticut Law: this Information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

PSYCHIATRIC INFORMATION

If the event that information released constitutes confidential psychiatric information protected under Connecticut Law: This information has been disclosed to you from records whose confidentiality is protected by state law. State law Prohibits you from making any further disclosure of it or of using it for any purpose other than that indicated above without The specific written consent by the person to whom it pertains, or as otherwise permitted by said law.

DRUG AND ALCOHOL ABUSE RECORDS

In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records 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 this information unless further disclosure is expressly Permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general Authorization for the 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.