



104507

MR#: \_\_\_\_\_  
Date Completed: \_\_\_\_\_  
Pages Copied: \_\_\_\_\_  
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, HIV related information, and reproductive services.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

#### FILL OUT BELOW TO DISCLOSE/OBTAIN

I authorize \_\_\_\_\_ to disclose /obtain health information to: \_\_\_\_\_  
Facility Name \_\_\_\_\_

Address \_\_\_\_\_ Street \_\_\_\_\_ Town \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_  
Tele#: \_\_\_\_\_ Fax#: \_\_\_\_\_

#### Method of Disclosure/obtain:

Mail  Verbal  Pick-up  Review  Electronic  MyChart Plus  Fax \_\_\_\_\_

#### The dates of service and the type(s) of information to be used or disclosed are as follows:

Reproductive Healthcare Services  Mental Health Record  Substance Abuse Records  HIV-Related Information

Date(s) of Treatment or Date Range: \_\_\_\_\_

<input type="checkbox"/> Abstract of Record	<input type="checkbox"/> Billing Records	<input type="checkbox"/> Consultations	<input type="checkbox"/> Discharge/Transfer Summary	<input type="checkbox"/> ED Record
<input type="checkbox"/> Entire Record	<input type="checkbox"/> History & Physical	<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> Psychiatric Evaluation	<input type="checkbox"/> MyChart Plus Enrollment
<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Progress Reports	<input type="checkbox"/> Other _____	<input type="checkbox"/> Psych/Neuro Testing
<input type="checkbox"/> Radiology Films	<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Treatment Plan		

#### The purpose of this disclosure or use is for the following reason: (Optional)

Medical  Legal  Disability  Insurance  At the request of the patient  Other \_\_\_\_\_

- This authorization will expire (date) \_\_\_\_\_. If date is not completed, this authorization will expire one year from the date of signature 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 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
- Legal guardian must sign this authorization if the patient is a minor.
- Minors receiving drug abuse, mental health, venereal disease treatment may sign their own authorization.

#### Authorization can be sent to:

Backus Health Information Management, 326 Washington Street, Norwich, CT 06360 - Fax# 860.892.2723  
 Charlotte Hungerford Health Information Management, 540 Litchfield Street, Torrington, CT 06790 – Fax# 860.496.6633  
 Hartford Healthcare at Home, 181 Patricia M. Genova Dr., HIM Dept. 3<sup>rd</sup> Fl, Newington, CT 06111 – Fax 860-380-1730  
 HH/IOL Health Information Management, 80 Seymour St, Bliss 104, Hartford, CT 06102 – Fax# 860.545.6764 or 545.6446  
 HOCC Health Information Management, 100 Grand Street, New Britain, CT 06050 - Fax# 860.224.5920  
 MidState Health Information Management, 435 Lewis Avenue, Meriden, CT 06451 - Fax# 203.694.7605  
 Natchaug Health Information Management, 189 Storrs Road, Mansfield Center, CT 06250 - Fax# 860.456.1381  
 Rushford Health Information Management, 1250 Silver Street, Middletown, CT 06457 – Fax# 860.346.9038  
 St. Vincent-Behavioral Health Information Management, 2800 Main Street Bridgeport, CT 06606 – Fax# 203-581-6556  
 Windham Health Information Management, 112 Mansfield Avenue, Willimantic, CT 06226 - Fax# 860.456.6885  
 HHCAG \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

Relationship to patient:  Self  Parent  Guardian  Conservator  Power of Attorney  
 Administrator / Executor of Estate  Documented Next of Kin

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.

**REPRODUCTIVE HEALTH CARE SERVICES INFORMATION**

If the event that information released constitutes reproductive health care services information protected under Connecticut Law: This information has been disclosed to you from records whose confidentiality may be protected by state law. A patient, or the patient's conservator, guardian, or other authorized representative has the right to withhold written consent to release this information, unless the law permits the release of reproductive health care services information without written consent, such as (1) pursuant to Connecticut law or the rules of court prescribed by the Connecticut Judicial Branch; (2) to a covered entity's attorney or insurer for use in the defense of an action or proceeding; (3) to the Commissioner of Public Health in connection with the investigation of a complaint, if such records are related to the complaint, or (4) if child abuse, abuse of an elderly individual, abuse of an individual who is physically disabled or incompetent or abuse of an individual with intellectual disability is known or in good faith suspected.