Connecticut Behavioral Health Associates, P. C.

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Client Name: _____ DOB: _____ SSN: _____ - _____ - _____

I understand that the information to be exchanged may contain protected substance abuse, psychiatric, and confidential HIV-related information (Protected Health Information).

I authorize Connecticut Behavioral Health Associates, P.C. to

☐ **Release** Protected Health Information to: and/or ☐ **Obtain** Protected Health Information from:

Facility/Agency/Person: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Protected Health Information that may be used or disclosed includes: [Check all that apply]

☐ Complete Medical Record ☐ Mental Health Information ☐ Admission Assessment
☐ Drug/Alcohol related information ☐ Progress Notes ☐ Discharge Summary
☐ HIV/AIDS relation information ☐ Medications
☐ Other (specify):

_____

Date of Treatment to be released / obtained:

☐ All Dates of Service ☐ Specified Dates: **Start Date:** _____ **End Date:** _____

The information released under this authorization will be used for the following purposes: [Check all that apply]

☐ Assess for intake purposes ☐ Provide Treatment ☐ Review History
☐ Coordinate Care ☐ Refer for services ☐ Other: _____

I understand this information will be used to provide comprehensive and coordinated services. I agree that a copy of this authorization will be as valid as the original. I understand this authorization will expire 30 days from date of discharge from the practice or one year from the date of my signature. I give this consent freely and voluntarily and understand that refusal to grant authorization will not prevent me from utilizing services upon acceptance to Connecticut Behavioral Health Associates, P.C.

I understand that I may revoke this consent at any time prior to the release of the above information by making the request in writing to Connecticut Behavioral Health Associates, P.C. but that any such revocation will not apply to information already released while this authorization was in effect. I understand that information, once disclosed to others, may be re-disclosed to entities not subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and therefore, may no longer be protected by HIPAA. The confidentiality of this record is required under chapter 899 of the Connecticut General Statutes as well as Title 42 of the United States Code. This material cannot be transmitted to anyone without your written authorization, as provided for in these statutes.

Print Name: _____ Date: _____

Signature of Client or Authorized Legal Representative: _____