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MEDICAL RECORDS RELEASE AUTHORIZATION

Patient's Name:_____ Date of Birth:_____

Parent's Name:_____ Telephone No.: (Home)_____

(Business)_____

I authorize the release of my medical records from:_____

I authorize the release of my medical records to:_____

AUTHORIZATION:
I hereby authorize the individual/entity listed above to release my own or my child's records described above, including AIDS/HIV, psychiatric, drug abuse and/or alcohol related information if applicable and use of the information for the purpose of:

- □ At the request of the patient
- □ Other:_____

I understand that if the recipient of the information is not an entity covered by the federal Privacy Rule, the information used or disclosed as described above, may be re disclosed by the recipient and is no longer protected by the Privacy Rule. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS related information and psychiatric/mental health information. I have been informed that my refusal to grant consent to release of information relating to psychiatric treatment will not jeopardize my right to obtain present or future psychiatric treatment except where disclosure of the communication and records is necessary for treatment.

I understand that I am not required to sign this Authorization as a condition of treatment, payment, enrollment or eligibility for benefits.

I understand that I may revoke this authorization in writing at any time, except to the extent that the above institution has already taken action in reliance on the authorization. Unless I revoke this authorization prior to such time, this authorization shall expire on 12 months from the date of signature. By signing below, I acknowledge that I have read and understand this Authorization form.

X _____ _____
SIGNATURE of Patient or Patient's Authorized Representative **TODAY'S DATE**

_____ _____
AUTHORIZED REPRESENTATIVE (please print name) **Relationship to Patient/Authority to Act on Patient's Behalf**

If the patient is a minor (under 18) or has a legal guardian, in most cases, this authorization must be signed by the patient's parent or legal guardian.

Filename: medrecrelauthoriza

NOTICE

PROHIBITIONS ON REDISCLOSURE

Psychiatric Records and Communications

In the event that the information released constitutes privileged psychiatrist-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 and Alcohol Abuse Records

In the event that the 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.

HIV Related Information

In the event that information released constitutes confidential HIV related information 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.