mental health connecticut

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
THIS IS A LEGAL DOCUMENT AND WILL NOT BE HONORED UNLESS IT IS COMPLETED IN FULL

Name of Client: _____ **DOB:** _____ **Last 4 SSN:** _____

I, the undersigned, authorize the above named facility to: ☐ **DISCLOSE** **information to** ☐ **OBTAIN** **information from**

Name of Person/Organization: _____

Address: _____ **City:** _____ **State:** ___ **Zip Code:** _____

Phone Number: _____ **Fax Number:** _____

Purpose of Release:

☐ Determining eligibility for service
☐ Implementing a recovery plan
☐ Compiling a comprehensive assessment
☐ Other: _____

Information to be released/obtained:

☐ Personal Data
☐ Psychiatric Information
☐ Psychosocial Information
☐ Vocational Information
☐ Mental Health Assessments
☐ Discharge/Transfer Summary
☐ Medical Information
☐ Substance Abuse Assessments and Services
☐ HIV & AIDS Assessments and Services
☐ Financial Information
☐ Rental Information
☐ Legal & Criminal History and Status
☐ Other: _____

This authorization, if not cancelled, will expire *(date not to exceed 365 days):* _____

Or when the following event occurs: _____

* I understand that refusal to sign this form will in no way affect my right to obtain present and future treatment, except where disclosure of such communications and records is necessary for treatment. I also understand that I may revoke this authorization at any time by signing the "cancellation/revocation" section below, except to the extent that action has been taken in reliance on it. I further understand that the confidentiality of psychiatric, substance abuse and HIV/AIDS records are protected under State and Federal Laws and cannot be disclosed without my written authorization unless otherwise provided for by law. The information disclosed by this facility pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal law. I understand that this authorization is voluntary and that information to be released/obtained may include medical, psychiatric, substance abuse and/or HIV/AIDS treatment information unless otherwise specified above.

_____ _____ _____ _____
Client Signature Date Authorized Legal Representative Signature Date

Cancellation:_____ Date: _____

NOTE: Confidentiality of psychiatric, drug and/or alcohol abuse and HIV records is required and no information from these specific records shall be transmitted to anyone else without written consent or authorization as provided under Connecticut General Statutes, Chapters 899c and 368x and Federal Regulations 42 CFR 2. These laws prohibit you from making any further disclosure without specific written consent of the person to whom it pertains. A general authorization for the release of information is NOT sufficient for this purpose.

Applicable Federal & State Laws

Portions of my records may be protected under federal confidentiality regulations (42 CFR Part 2 and CPA89-246) and cannot be disclosed without my written consent unless otherwise provided in the regulations.

Psychiatric Records and Communications

In the event that information released constitutes privileged psychiatric 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. A copy of the consent form setting forth any limitations shall accompany the disclosure. See C.G.S. sections 52-146d through 52-46i inclusive.

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 CFP Part 2.

HIV Related Information

In the event that information released 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. See C.G.S.19a-585.