The Connection

AUTHORIZATION FOR RELEASE OF CLIENT INFORMATION – _____

(Enter Program Name)

Client Name: _____ Date of Birth: _____ Today's Date: _____

Subject to the statements on the following page, I, the undersigned client, hereby authorize _____ to *(please initial):*

____ **receive** Protected Health Information from the following; **AND/OR**

____ **disclose** Protected Health Information to the following:

Agency/Facility/Person: _____

Address: _____

Contact Name: _____ Phone: _____

Email (preferred): _____ Fax: _____

The nature and extent of Protected Health Information to be used, received, and/or disclosed *(please initial)***:**

___ Admission/transfer to hospital/another facility
___ Assessments/Evaluations
___ Attendance, Scheduling, Security Information
___ Dates of admission and discharge
___ Diagnosis
___ Discharge/Transfer Information
___ Employment/Vocational Information
___ Entire medical record
___ Lab Results
___ Legal/Court Information
___ Medical/Physical Exams
___ Public Assistance/Entitlements
___ Treatment/Progress/Chrono notes
___ Treatment/Service/Action Plans
___ Other: _____

If the record(s) marked above contain the following types of Personal Health Information, I authorize the release of information relating to *(please initial)***:**

____ Mental or behavioral health
____ Substance use disorder
____ HIV/AIDS

The information marked above can be disclosed for the following time period *(please initial)***:**

___ All information maintained **at any time** by _____ and/or _____; **OR**

___ Information maintained: From date: _____ To date: _____

Limitations on disclosure *(if any; if none write "none")*: _____

Please specify the purpose(s) for which the information is being requested by this Authorization *(please initial)***:**

___ At the request of the individual; **OR** ___ Other: _____

This Authorization, if not revoked, will expire (*please initial)***:**

___ One (1) year after I have completed my evaluation/treatment/services at the _____; **OR**

___ Other: _____*(Specify the date, event or condition when this authorization expires)*

The Connection, Inc. Client Name: _____

Authorization for Release of Client Information – _____ Date: _____
(program name)

I understand that by signing this Authorization I am agreeing to the use, receipt, or disclosure of the above marked information. I also understand that I may revoke this Authorization at any time by providing written notification to the privacy officer of the party making the disclosure, except to the extent that action has been taken in reliance on this Authorization.

I understand that generally _____*(name of program)* may not condition my treatment or continued treatment on whether or not I sign this authorization and I may refuse to sign it. In certain limited circumstances I may be denied treatment if I do not sign a consent for disclosures relating to treatment, payment, or program operations. I understand that the information disclosed under this authorization may be subject to further disclosure by the recipient unless protected by the confidentiality laws described below. I understand that I am entitled to a copy of this authorization form. I agree that a copy of this authorization will be as valid as the original.

_____ _____

Print Name of Client or Personal Representative

If not signed by client, please describe relationship/authority to sign for client:

_____ _____

Client Signature (or parent/guardian/representative)

Date

_____ _____ _____

Print Staff Name Staff Signature Date

STATEMENTS REGARDING CONFIDENTIAL INFORMATION

Any information released by a program to authorized persons is subject to the following notices:

Psychiatric Information: In the event that information released constitutes confidential psychiatric information protected under Connecticut law:

"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 consent or other authorization as provided in the aforementioned statutes."

Substance Use Disorder Information: In the event that information released is protected by the U.S. Department of Health and Human Services Confidentiality of Substance Use Disorder Patient Records regulations (42 C.F.R. part 2):

*"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 information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed 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 (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65."*

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."*