

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that the records to be released may contain information pertaining to Medical, Psychiatric, Drug and/or Alcohol Abuse Treatment, and/or Confidential HIV (AIDS) related information.

Patient Name (include name at time of hospitalization if different) _____

Date of Birth _____

Social Security Number _____

I authorize Connecticut Valley Hospital to RELEASE information <u>to</u> : Name of Person or Agency: _____ _____ (Address) _____ _____ _____
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I authorize Connecticut Valley Hospital to OBTAIN information <u>from</u> : Name of Person or Agency: _____ _____ (Address) _____ _____ _____

Dates of Treatment Covered by this Release: <input type="checkbox"/> All prior episodes of care, through discharge from present episode of care <input type="checkbox"/> Limited to the following date(s): _____

Please Send Requested Information To:
**CONNECTICUT VALLEY HOSPITAL
 HEALTH INFORMATION MANAGEMENT**
 Attention: _____
P.O. Box 351 Middletown, CT. 06457

<p style="text-align: center;">Information to be Released/Obtained <i>Check appropriate box(es)</i></p> <input type="checkbox"/> Psychiatric Evaluation <input type="checkbox"/> Psychological Evaluation <input type="checkbox"/> Psychosocial History and Assessment <input type="checkbox"/> History and Physical Examination <input type="checkbox"/> Diagnostic Reports: ___ PPD ___ X-Ray ___ EEG ___ EKG ___ Laboratory <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Other (specify): _____
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<p style="text-align: center;">Purpose of Release <i>Any other use is prohibited</i></p> <input type="checkbox"/> To assist with Evaluation and Treatment <input type="checkbox"/> Placement/Referral Purposes <input type="checkbox"/> Benefit determination (includes Medicare/Medicaid) <input type="checkbox"/> Case Management coordination <input type="checkbox"/> Social Security Disability Determination <input type="checkbox"/> Other (specify): _____ _____ _____

This authorization if not cancelled, will expire: _____
 Event or condition upon which this authorization expires or date not to exceed 12 months.
 (If blank, authorization will expire 12 months from date of signature below.)

I understand that refusal to grant permission will in no way effect my right to obtain present and future treatment, except where disclosure of such communication and records is necessary for treatment. I understand that I may revoke this authorization at any time (not retroactively), by signing the "Cancellation/Revocation" section below, except to the extent that action has been taken in reliance on it (i.e. probation, parole, etc.). **This authorization, if not revoked earlier by me, will expire when acted upon or in one year of signature.** I further understand that the Confidentiality of psychiatric, drug and/or alcohol abuse and HIV records are protected under State and Federal law and cannot be disclosed without my written authorization unless otherwise provided for by law. I understand that I may make a request to inspect and/or copy the information to be used and that the agency will provide me with a copy of this signed authorization. The information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by Federal law.

Patient Signature: _____ Date: _____

*Personal Representative: _____ Date: _____

Witness Signature: _____ Date: _____

CANCELLATION/REVOCATION:

Patient/Legal Representative Signature: _____ Date: _____

*If this form has not been signed by the patient, please state signer's authority and provide a copy of legal appointment.

Conservator/Guardian Executor of Estate Other (specify): _____

Please Note: This is a legal document and will not be honored unless it is completed in full.