

Hartford Nurturing Families Network
Authorization To Release Information

Parent Name: _____ Child's Name: _____
Parent DOB: _____ Child's DOB: _____
Parent Address: _____ Delivery Date & Hospital: _____
Parent Phone: _____
Parent Record # (If known): _____ Other Parent Identification: _____
(i.e. Social Security #)

I, _____, authorize _____
(Name of agency, organization or institution)

To RELEASE the following information to: _____

 To OBTAIN the following information from: _____

(Name and address of agency, organization or institution)

I authorize the release of the following information:
 All medical information regarding pregnancy, prenatal care and delivery of the above-referenced child(ren)/delivery date
 Compliance/noncompliance within the Hartford Nurturing Families Network and affiliated programs
 Alcohol and/or drug treatment related information HIV/AIDS related information
 Psychiatric, psychological or other counseling records Other (specify): _____

Description of the reason or purpose of this use or disclosure (any other use is prohibited):

Expiration Date or Event:

1. I understand that I may revoke this Authorization at any time by providing written notice to the provider. I understand that I may not be able to revoke this Authorization if the provider has taken action in reliance on the Authorization, or if the Authorization was obtained as a condition of obtaining insurance coverage.
 2. I understand that the provider will not condition treatment, payment, enrollment or eligibility for benefits based on my signing this Authorization. I acknowledge that I am signing this Authorization freely, and no one has coerced or pressured me to sign the Authorization.
 3. I understand that the protected health information disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by the Federal Privacy Regulations.
 4. I understand that if the protected health information that is disclosed under this Authorization is confidential HIV/AIDS related information or alcohol or drug abuse related information, the recipient may not re-disclose that information under Connecticut State Law.
 5. I acknowledge that I have carefully reviewed this Authorization and understand its provisions. A copy of this Authorization will be given to me.
 6. A copy of this Authorization shall be considered as effective as an original.
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Signature of Client or Authorized Representative

Date: _____

Signature of Authorized Agency Staff

Date: _____