hfsc Hospital for Special Care

Hospital for Special Care
2150 Corbin Avenue
New Britain, CT 06053

Phone: 860-827-4863
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www.hfsc.org

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

I, the undersigned patient (or legal representative), hereby authorize Hospital *for Special* Care to use and disclose health information , including, if applicable, information related to the diagnosis or treatment of **mental illness, drug and/or alcohol abuse, and confidential HIV-related information**, regarding:

Patient Information	Party to Receive Information
Name:_____ AKA/Maiden Name:_____ Date of Birth: _____/_____/_____ Address: _____ _____ Email:_____ Phone #:_____ The purpose of this use or disclosure is for the following reason: ☐ Medical ☐ Disability Benefits ☐ Insurance ☐ Legal ☐ At the request of the patient or legal representative	The information may be disclosed to and used by the following party (or category of persons): Name:_____ Address: _____ _____ Email:_____ Phone #:_____ FAX #:_____ Format you would like to receive* disclosed information in: ☐ Paper ☐ CD/USB (Compact Disk) ☐ FAX ☐ Email (subject to confirmation) Method of Delivery (For Paper or CD only) ☐ Mail to address listed above ☐ Pick up On-site

Dates of Treatment covered by this Authorization: From _____/_____/_____ To _____/_____/_____

The types of information to be used or disclosed is as follows:

[ ] **Continuing Care documents** (includes: Next of Kin/Personal Representative, Primary Care Provider, Advance Directives, Problem List, Family History, Social History, Allergies/Adverse Reactions/Alerts, Medications, Immunizations, Procedures and Discharge Summary)

[ ]	Dental X-Rays	[ ]	Speech Therapy
[ ]	Discharge Summary	[ ]	Physical Therapy
[ ]	Discharge Instructions	[ ]	Occupational Therapy
[ ]	History & Physical Exam	[ ]	Psychiatric/Behavioral Health Notes
[ ]	Consultation Reports	[ ]	Abstract of Record
[ ]	Clinical Progress Notes/Assessment	[ ]	Operative Report
[ ]	Procedure Notes/Operative Report	[ ]	Review Medical Record On-site
[ ]	Pathology Report	[ ]	Billing Records
[ ]	Lab Reports	[ ]	Verbal Report
[ ]	Radiology Reports	[ ]	Outpatient Records Only
[ ]	Immunizations		

Other (please specify):_____
_____
Limitations on Disclosure _____

* ***HSC discourages delivery of information electronically using methods that cannot be secured by encryption (such as personal email address, CD to be sent via US mail, etc.). The individual signing this release form acknowledges that he/she is responsible for any loss or unauthorized disclosure of the information if he/she requests HSC to use an electronic method of disclosure despite this risk.***

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1. I understand that this authorization will expire **the later of** one year after I have signed the form, 6 months after my discharge or last date of outpatient treatment, or other date as specified here: _____/_____/_____.
2. I understand that I may revoke this authorization at any time by notifying the Health Information Management department in writing, and it will be effective on the date HSC is notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations.
4. I understand that I am not required to sign this form in order to receive treatment at HSC.
5. I understand that there may be a fee for copying or processing a copy of my medical record.
6. If you (or the patient) is a Veteran, please indicate here_____, there is no charge if this request is related to a claim or appeal for benefits

*	*	*
Patient Signature (or authorized representative)	**Print Name**	**Date**

Patient unable to sign due to: _____

Relationship to patient: ☐ Parent ☐ Guardian ☐ Conservator ☐Executor of Estate ☐Power of Attorney

The patient's parent or legal guardian must sign this authorization if the patient is a minor (under 18 years old) or has a legal guardian. Minors may sign their own authorization for records related to drug/alcohol abuse treatment, sexually transmitted diseases or HIV/AIDS related information, and in certain circumstances, mental health treatment records.

NOTICE TO RECIPIENTS OF INFORMATION - PROHIBITIONS ON REDISCLOSURE

Psychiatric Records and Communications:
In the event that the information released constitutes psychiatrist-patient communications under state 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 authorization as provided in the aforementioned statutes.

Drug and Alcohol 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 the 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 HIV-related information under Connecticut law (CGS 19a-585(a)):

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.

HIM OFFICE USE ONLY

Requester I.D. Verified by: _____ MRN:_____ Date Copies Mailed: _____

A copy of this form must be given to the patient or patient's representative.

PATIENT REVOKED THIS AUTHORIZATION ON_____/_____/_____. Noted by:_____

ROI: rev.6/23/2016 Form: ROIAUTH