

**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

Subject to the statements printed on the back, I, the undersigned patient or legal representative, hereby authorize \_\_\_\_\_ to use or disclose herein information including, if applicable, information relating to the diagnosis or treatment of mental illness, drug and/or alcohol abuse and HIV related information regarding:

**Patient Name:** \_\_\_\_\_

**Birth Date:** \_\_\_\_\_

The information may be disclosed to and used by the following:  NAME: <u>Paul Levin, Esq.</u>  ADDRESS: <u>100 Pearl Street, Suite 1407</u> <u>Hartford, CT 06103</u>  _____  TEL #: <u>860-249-7226</u> FAX #: <u>860-249-7227</u>	The dates of service and the type(s) of information to be used or disclosed are as follows:  Discharge date: _____ Dates: _____  <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border: none;"> <input type="checkbox"/> History &amp; Physical  <input type="checkbox"/> Discharge Summary  <input type="checkbox"/> ED Record  <input type="checkbox"/> Billing Records  <input type="checkbox"/> Other _____   <input type="checkbox"/> Patient's entire medical record and complete billing statement                 </td> <td style="width: 33%; border: none;"> <input type="checkbox"/> Operative Reports  <input type="checkbox"/> Consultations  <input type="checkbox"/> Progress Notes  <input type="checkbox"/> Radiology Report  <input type="checkbox"/> Laboratory Report  <input type="checkbox"/> Pathology Reports  <input type="checkbox"/> Radiology Films                 </td> <td style="width: 33%; border: none;">                 _____                  _____                  _____                  _____                  _____                  _____                 </td> </tr> </table>	<input type="checkbox"/> History & Physical <input type="checkbox"/> Discharge Summary <input type="checkbox"/> ED Record <input type="checkbox"/> Billing Records <input type="checkbox"/> Other _____  <input type="checkbox"/> Patient's entire medical record and complete billing statement	<input type="checkbox"/> Operative Reports <input type="checkbox"/> Consultations <input type="checkbox"/> Progress Notes <input type="checkbox"/> Radiology Report <input type="checkbox"/> Laboratory Report <input type="checkbox"/> Pathology Reports <input type="checkbox"/> Radiology Films	_____ _____ _____ _____ _____ _____
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Method of Disclosure:  <input type="checkbox"/> Mail <input type="checkbox"/> Verbal <input type="checkbox"/> Pick-up <input type="checkbox"/> Review	The purpose of this disclosure or use is for the following reason:  <input type="checkbox"/> Medical <input checked="" type="checkbox"/> Legal <input type="checkbox"/> Disability <input type="checkbox"/> Insurance <input type="checkbox"/> At the request of the patient <input type="checkbox"/> Other _____			

This authorization will be valid for a period of one year from the date below. I understand that I may revoke this authorization at any time by notifying Patient Relations in writing, but if I do, it will not have any effect on actions that the hospital or physician's office took before it received the revocation.

I understand that under applicable law, the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations.

I understand that my treatment or continued treatment by \_\_\_\_\_ is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it.

I understand that I may inspect or copy the information to be used or disclosed.

The patient's parent or legal guardian must sign this authorization if the patient is a minor (under age 18) or has a legal guardian. Minors receiving drug abuse treatment or treatment of venereal disease may sign their own authorization.

\_\_\_\_\_  
Signature of Patient or Legal Representative

Date: \_\_\_\_\_

\_\_\_\_\_  
Witness

*If signed by the Legal Representative, indicate your relationship to the Patient below and provide appropriate documentation to verify your Authority:*

Parent    Guardian    Conservator    Executor of Estate    Power of Attorney  
 Other \_\_\_\_\_

## **NOTICE**

### **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.

### **PSYCHIATRIC INFORMATION**

In the event that information released constitutes confidential psychiatric 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 or of using it for any purpose other than that indicated above without the specific written consent by the person to whom it pertains, or as otherwise permitted by said law.

### **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 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.