CCMC Faculty Practice Plan, Inc.
282 Washington Street
Hartford, CT 06106

AUTHORIZATION FOR RELEASE OF PATIENT-IDENTIFIABLE HEALTH INFORMATION
(Including Psychotherapy & HIV Notes)

Patient Name: _________________________________ MR#: __________________________

Address: ______________________________________ Date of Birth: ___________________

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. I authorize the CCMC Faculty Practice Plan, Inc. and any of its staff to make the disclosure.
3. The type and amount of information to be used or disclosed is as follows (include dates where appropriate)

[ ]Problem List [ ] Medication List [ ] List of Allergies [ ] Immunization Record
[ ] Most Recent History & Physical [ ] Most Recent Discharge Summary
[ ] Laboratory Results from (date)_____________ to (date)________________
[ ] X-ray and Imaging Reports from (date)_____________ to (date)________________
[ ] Consultation Reports from (Doctors' Names)____
[ ] Entire Record Other: ____

Additional Release Information

If the release material contains confidential psychiatric communication, as designated in Connecticut General Statutes Sections 52-146d through 52-146I, inclusive, please note the following:

> **"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." A copy of the consent form setting forth any limitations shall accompany the disclosure.**

Check all that apply: ☐ **Drugs** ☐ **Abuse** ☐ **Alcohol** ☐ **HIV**

____ ______________________________
Signature of Patient or Legal Representative **Date**

4. This information may be disclosed to and used by the following individual or organization:

   Name: ____

   Address: ____

   For the Purpose of: ____

5. I understand that the information in my health record may include information relating to acquired immunodeficiency syndrome (ADS), or human immunodeficiency virus (HIV). It may also include information about behavior or mental health services. I understand that I may refuse to grant the consent to release this type of information.
6. If any of the information to be released relates to treatment for alcohol and drug abuse, I understand that there are special requirements for my consent to release as found in Part 2 of Title 42 of the Code of Federal Regulations (CFR), which prohibits the further release of that information without my consent, as referenced in the federal regulations, or as otherwise permitted by law.
7. I understand that no psychotherapy notes may be disclosed by my signing the above statement.
8. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition, not to exceed 12 months: __________________. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.
9. I understand that, I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Medical Records Manager. I acknowledge that I am signing this authorization freely, and no one has coerced or pressured me to sign the authorization.

____ ______________________________
Signature of Patient or Legal Representative Date

____ ______________________________
If Signed by Legal Representative, Relationship to Patient Signature of Witness

Process/Sent by:____ Date:________________________________