AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION PURSUANT TO HIPAA

GRIFFIN HEALTH

130 Division Street, Derby CT 06418
www.griffinhealth.org

Patient Name: _____ ____Date of Birth: _____

Patient Address: _____City/State/Zip_____Phone:_____

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth in this form. In accordance with Connecticut State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL/DRUG TREATMENT, MENTAL HEALTH TREATMENT AND CONFIDENTIAL HIV/AIDS RELATED INFORMATION only if I place my initials on the appropriate line in Item 12(b). In the event the health information described below includes any of these types of information, and I initial the line on the box in item 12(b), I specially authorize release of such information to the person(s) indicated in Item 10.
2. If I am authorizing the release of information relating to ALCOHOL/DRUG TREATMENT, MENTAL HEALTH TREATMENT and CONFIDENTIAL HIV/AIDS RELATED INFORMATION, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law.
3. I have the right to revoke this authorization at any time by revoking authorization in writing. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that upon request, I will be provided with a copy of this signed authorization form.
5. I understand that there may be a fee associated with producing the records I am requesting.
6. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
7. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
8. I understand that if I am seeking the above-referenced patient's medical records (minor age 13-17) on the basis that I am his/her parent or legal guardian, I am precluded from having access to the information related to the patient's pregnancy test results, treatment for venereal disease or those Items listed in 12(b) and (c), with the exception of genetic testing, unless the patient has specifically authorized release of that information to me by listing my name in Item 10 below and signing this form.

9. Name and address of health provider or entity to release information:

Facility/Name: _____
_____
Address: _____
City/State/Zip: _____
Phone: _____
Fax:_____

10. Name and address of individual or entity to whom I authorize this information to be disclosed to: □ Self Request –Address as above.

Facility/Name: _____
Address: _____
City/State/Zip: _____
Phone: _____
Fax:_____
Email:_____

11. Date(s) of Service to be Released:

12. (a) Specific Information to be released:

□ The Following Specific Sections of the Record **ONLY**:

□ Discharge Summary	□ Laboratory Report	□ Emergency Dept. Record	□ Radiology Report	□ Operative/Procedure Report
□ History & Physical	□ Pathology Report	□ Consultation Report	□ Radiology Imaging	□ PT/OT/ST Rehabilitation Report
□ Progress Note	□ Cardiology Testing	□ Pulmonary Testing	□ Sleep Lab Record	□ Entire Record
□ Records from Other Providers Included in Chart	□ Other:			

b) Include: (*Indicate by Initialing)*

□ _____ **Alcohol/Drug Treatment**
□ _____ **Confidential HIV/AIDS Related Information**
□ _____ **Mental Health Information (other than psychotherapy notes)**
□ _____ **Genetic Testing**

c) Psychotherapy(*Indicate by Initialing*) □ _____ ***Psychotherapy Notes Only*** **(If this form is being used to authorize the release of psychotherapy notes, this same form must be filled out again, separately, to authorize the release of any other health information)**

13. Reason for release of information:

□ Personal use □ Legal □ Other:

14. This authorization will expire within 1 year from signed date unless otherwise indicated by date in this box:

15. If not patient, name of person signing form:

16. Relationship to patient:

By signing this form, I acknowledge that I have reviewed this form in its entirety and my questions about this form have been answered.

_____ _____

Signature of patient or representative authorized by law **Date**

NOTICE TO RECIPIENT OF INFORMATION: Federal and state law prohibit making any further disclosure of alcohol and/or drug abuse information (42 CFR Part 2), HIV-related information (Chapter 368x of the C.G.S.), psychiatric or other mental health information (Chapter 899 of the C.G.S.), without specific written authorization. If the disclosure contains information related to HIV/AIDS, alcohol or drug abuse, the following notice applies:
This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2) or state law. The Federal rules or state law 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 said law. 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.

Authorization Revocation Date:_____ Signature:_____