easterseals
Capital Region & Eastern Connecticut

Authorization to Disclose / Obtain Health Information

Subject to the statements printed on the back, I, the undersigned person or legal representative, hereby authorize the use and disclosure of health information including, if applicable, information relating to the diagnosis or treatment of mental illness, drug and/or alcohol abuse, and HIV related information.

Patient Full Name: _____

Patient Date of Birth: _____ **Patient Phone Number**: _____

Patient Address (street, city, state, zip): _____

Fill out for Easterseals CR&EC to **DISCLOSE**	Fill out for Easterseals CR&EC to **OBTAIN**
I authorize **Easterseals CR&EC** to disclose health information to: Name: _____ Address: _____ _____ Phone #: _____ Fax #: _____	I authorize _____ _____ *(Name and address of provider/facility)* to release health information to: *Easterseals CR&EC* *100 Deerfield Rd, Windsor, CT 06095* *Phone #: 860-270-0600 Fax #:* ***860-748-4432***

Method of Disclosure: ☐ Mail ☐ E-Mail ☐ Verbal ☐ Pick-up ☐ Fax

Date(s) of Treatment or Date Range: _____

The type(s) of information to be used or disclosed are as follows (check below)**:**

☐ History & Physical	☐ Labs, EEG/EKG, Radiology Reports	☐ Consultations	☐ Mental Health Record
☐ ED Record	☐ Psych/Neuro Evaluations	☐ Progress Notes	☐ Substance Abuse Records
☐ Discharge Summary	☐ Procedure/Operative Reports	☐ Entire Record	☐ HIV-Related Info

The purpose of this disclosure or use is for the following reason (check below)**:**

☐ Medical treatment ☐ Legal ☐ Disability ☐ Insurance ☐ Other: _____

- This authorization will be valid for a period of one year from the date below, unless otherwise specified here: Expiration Date: _____. I understand that I may revoke this authorization at any time by notifying the Admissions Department in writing. I understand that this revocation will not apply to information that has already been released in response to this authorization.
- 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 by protected by federal privacy regulations.
- I understand that I may refuse to sign this authorization and that my treatment or continued treatment by Easterseals CR&EC is in no way conditioned on whether or not I sign this authorization.
- I understand that I may inspect or copy the information to be used/ disclosed and that there is a charge for copies.
- The parent or legal guardian must sign this authorization if the patient is a minor or has a legal guardian.

_____ _____ _____
Signature of Patient *(or Legal Representative, if applicable)* | Printed Name | Date

If signed by other than the patient, relationship to patient: _____

_____ _____
Signature of Witness | Date

NOTICE: *A photocopy of this authorization shall be considered as effective and valid as the original.*

The requested information will be used to aid in the planning for and delivery services to the above named client/patient. All information will be used in accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) and other Federal and State laws and regulations. If this disclosure contains mental health/psychiatric information, drug and alcohol abuse records/information, and/or HIV-related information, the following shall apply:

MENTAL HEALTH RECORDS / PSYCHIATRIC INFORMATION
In the event that information released constitutes confidential psychiatric information protected under Connecticut Law: This information has been obtained from records whose confidentiality is protected by state law. State law prohibits making any further disclosure of this information or of using it for any purpose other than indicated above without the specific written consent by the person 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 obtained from records protected by the Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit 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 to obtain 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 confidential HIV related information protected under Connecticut Law: This information has been obtained from records whose confidentiality is protected by state law. State law prohibits making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization to obtain medical or other information is NOT sufficient for this purpose.