-

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Manisha Juthani, MD
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
CONNECTICUT NEWBORN SCREENING PROGRAM
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____

I authorize the **State of Connecticut, Department of Public Health (DPH)** to disclose the health information indicated below regarding the patient identified above to:

Name: _____
Facility: _____
Address: _____
_____
Tele#: _____ Fax#_____

Method of Disclosure: ☐ Mail ☐ Verbal ☐ Pick-up ☐ Review ☐ FAX

Type of Information that DPH is authorized to disclose (check all that apply)

☐ Laboratory Reports ☐ Mental health records* ☐ Substance abuse records**

☐ HIV related information*** ☐ Other _____
(specify)
Dates of service: _____
This disclosure or use is for the following reason:

☐ Medical ☐ Legal ☐ Disability ☐ Insurance ☐ Individual's request ☐ Other_____

Expiration: This authorization expires on _____
(specify date or event)

- I understand that I may revoke this authorization at any time by notifying DPH in writing; however, any revocation will not apply to information that has already been released in response to this authorization.
- Information disclosed under this authorization may be re-disclosed and no longer protected by privacy regulations.
- DPH will not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this authorization.

Phone: (860) 920-6500 • Fax: (860) 920-6718
Telecommunications Relay Service 7-1-1
395 West Street
Rocky Hill, Connecticut 06067
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

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

_____ _____
Patient(signature) or Legal Representative(printed name & signature) **Date**

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

_____ _____
Name of Witness **Signature of Witness**
If signed by the legal Representative attach appropriate documentation to verify authority.

Authorization can be sent to:

Jeffrey C. Curran, QA Manager
Dr. Katherine A. Kelley State Public Health Laboratory
395 West Street
Rocky Hill, CT 06067

NOTICE TO RECIPIENT OF INFORMATION:

PSYCHIATRIC INFORMATION

* Under Chapter 899 of the Connecticut General Statutes, psychiatric records are confidential and shall not be transmitted to anyone without consent or other authorization. Thus, you cannot further disclose psychiatric records or the information contained in them without first obtaining specific written consent or as otherwise permitted under said laws.

DRUG AND ALCOHOL ABUSE RECORDS

** Substance abuse records contain information that is protected by the Federal confidentiality rules at 42 C.F.R. Part 2 ("Federal rules"). The Federal rules prohibit you from further disclosing any of this information unless the person identified in the information provides express, written consent for such release or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is not sufficient for express written consent purposes. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

HIV RELATED INFORMATION

*** Under state law, records containing HIV information are confidential and cannot be further disclosed unless the person identified in the records provides express written consent for such disclosure, or as otherwise permitted by state law. A general authorization for the release of medical or other information is not sufficient for express written consent purposes.