Connecticut Medical Home Initiative (CMHI) for Children and Youth with Special Health Care Needs (CYSHCN)*

Authorization for Release of Protected Health Information Form

I/We the undersigned hereby authorize any and all physicians, medical providers, medical facilities, therapists, schools, early intervention services, medical insurance companies, and any other health care professional or agency involved in my child's care to communicate with and/or release information, which may include information relating to medical, psychiatric, alcohol, and drug abuse, HIV/AIDS, Sickle Cell Disease, to any or all of the following:

CT Medical Home Initiative Children and Youth with Special Healthcare Needs Programs:

- ☐ **North Central Region: Connecticut Children's Medical Center, Center for Care Coordination**
- ☐ **Eastern Region: United Community and Family Services, Inc.**
- ☐ **Eastern Region: Generations Family Health Center, Inc**
- ☐ **Northwest Region: St. Mary's Hospital, Inc.**
- ☐ **South Central Region: Family Centered Services of CT**
- ☐ **Southwest Region: Stamford Hospital**
- ☐ **CT Medical Home Initiative at FAVOR**

Other:

- ☐ **United Way of Connecticut 2-1-1 Infoline Child Development Infoline**
- ☐ _____

Child's Name: _____ Date of Birth:

mm	dd	yy

Please specify the time period for the information you authorize to be disclosed:

☐ All information maintained at any time by the discloser, or

☐ Information maintained by the Discloser from:

mm	dd	yy	to:	mm	dd	yy

For the purpose of evaluation and/or care coordination --

The confidentiality of this record is required under Connecticut General Statutes 19a-25. The material shall not be transmitted to anyone without written consent or authorization as provided in the aforementioned statutes.

I may revoke this authorization at any time, except to the extent action has been taken in reliance thereon. This authorization, unless expressly revoked earlier, **expires on one year from date signed**. I understand that the information released here may be subject to re-disclosure by the recipient and may no longer be protected by the above-named facilities' privacy practices or applicable privacy law.

Signature: _____ Date: _____

Signature: _____ Date: _____

If signed by the patient's personal representative, describe the legal authority of the representative to act on behalf of the patient:

I acknowledge the offer and/or receipt of the Notice of Privacy Practices from all current providers of care. (HIPAA)

Signature: _____ Date: _____

*The CMHI for CYSHCN is a program supported by the State of CT Department of Public Health. Information is available on their website at www.ct.gov/dph/medicalhome . Revised 11.2020