Office of the Healthcare Advocate
STATE OF CONNECTICUT

Please complete this form and return via

Mail: Office of the Healthcare Advocate
Attention: Laura Morris
P.O. Box 1543
Hartford, CT 06144-1543

or

Fax: (860) 331-2499

Authorization for Use and Disclosure of Private/Protected Health Information

NOTE: Your enrollment in a health plan, eligibility for benefits, processing and payment of claims, or treatment is not a condition of this authorization!

I. Identification of Person Authorizing Release *(The following is needed for verification. Please complete all applicable items.)*

Parent/Legal Guardian/Child Over the Age of Sixteen:_____ Date of Birth: _____
Address: _____ Zip Code (+4): _____
Telephone Number(s): (H): _____ (W): _____
(C): _____ (Fax): _____
E-mail Address:* _____
Would you like primary communication via e-mail? ☐ YES ☐ NO

I am the Person Authorized to Release Medical Information for: ☐ SELF ***(skip to I.A)*** ☐ CHILD UNDER 16YO/FAMILY MEMBER ☐ OTHER

Name of Member/Patient:_____ Date of Birth: _____
Address: _____ Zip Code (+4): _____
Telephone Number(s): (H): _____ (W): _____
(C): _____ (Fax): _____
E-mail Address:* _____

Section I.A – Requested Demographic Information (used solely for data reporting purposes only)

The Patient is: ☐ Asian-American ☐ Black/African-American ☐ Hispanic/Latino ☐ Native American
☐ White / Caucasian ☐ Unknown/Other

The Patient is: ☐ Single ☐ Married ☐ Separated ☐ Divorced
☐ Civil Union ☐ Domestic Partner ☐ Widowed

The Patient is: ☐ Full-Time Employed [☐ one job ☐ two jobs+ ☐ self-employed]
☐ Part-Time Employed ☐ Student/Child ☐ Retired ☐ Unemployed [☐ looking ☐ not looking for work]
☐ Disabled/Not Working ☐ Unknown

The Patient is a Veteran? ☐ YES ☐ NO

* OHA uses e-mail to communicate with clients. Please be advised that our e-mail communications are made through a secured server, which requires you to complete a one-time set-up to access the secured e-mail(s).

** Please complete the federally Requested Demographic Information section; this information is used solely for aggregate reporting purposes and will not be shared with any person or entity.

Name of Insurance Company (i.e., Anthem, Teamsters, TriCare, Cigna)**:**_____

Patient ID Number: _____ Group or Account Number:_____

Subscriber's (Employee) Name:_____

Subscriber's Relationship to Participant:_____ Subscriber's Employer Name:_____

Name of Additional Insurance Company:_____

Patient ID Number: _____ Group or Account Number:_____

Subscriber's (Employee) Name:_____

Subscriber's Relationship to Participant:_____ Subscriber's Employer Name:_____

Name of Public Insurance (i.e. HUSKY, Medicaid, Medicare, if applicable):

Name as shown on grey Connect Card/Medicare Card:_____

ID number on the grey Connect Care/Medicare Card:_____

II. Description of Private Health Information to be Released: Describe what information you are authorizing to be released. *Please include the names and address of providers from whom information should be obtained on a separate sheet.*

All insurance information necessary to assist in processing the claims, appeals and grievances with insurers listed under Section I. In addition any and all records including admissions, intake summaries, medical evaluations, psychological/psychiatric evaluations, lab results, progress notes, recommendations, treatment plans, and discharge summaries related to any and all treatment for providers listed on the attached sheet.

In addition, if you agree that the following types of information may be released, please indicate so by checking the appropriate boxes:

☐ Mental Health Records/Progress Notes ☐ Other_____

☐ Sexual/Physical/Mental abuse

☐ Alcohol /Substance Abuse Records*

* If you want to authorize the use or disclosure of other protected health information as well, an additional form must be submitted. Please see the last page of this authorization, which describes in more detail further disclosure of psychotherapy notes, HIV/AIDS records and alcohol & substance abuse records.

Who can release and receive the information (limitations on disclosure): Insert the person(s)/company(-ies) allowed to release the information **and** the person(s)/company(ies) allowed to receive the information. The following person(s)/company(ies) are allowed to release and receive the information as requested:

- *The Office of the Healthcare Advocate* ☒ Release Information ☒ Receive Information
- *State of Connecticut Insurance Department* ☒ Release Information ☒ Receive Information
- *Insurance Companies listed in Section I* ☒ Release Information ☒ Receive Information

  DCF, Solnit Center, HUSKY and CT BHP ☒ Release Information ☒Receive Information
  (***solely for the purpose of facilitating insurance issues identified in Section II***)
- _____ ☐ Release Information ☐ Receive Information

The following information may be provided to the Office of the Healthcare Advocate and (include name and address):

Insurance companies listed in section I.
All information described in Section II may be provided to the Office of Healthcare Advocate at P.O. Box 1543, Hartford, CT 06144.

III. Purpose of this release information:

☒ At the request of the covered individual;
☐ If not requested by the individual, please state the purpose of the release of information:_____

IV. Expiration Date: If not previously revoked, this authorization will terminate on the earliest of the following dates:

a. the date the individual's coverage ends; or
b. one year from the signature date below; or
c. upon the following date, event or condition: _____

V. Signature: A copy of this authorization is available to me, or to my authorized representative, upon request and will serve as the original. A copy of this authorization will also serve as the original if multiple disclosures are required. I understand that if this information is to be received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by federal privacy regulations, my information described above may be redisclosed by the recipient and no longer protected by federal privacy regulations. This authorization is subject to revocation at any time upon written notice to the person(s)/company(ies) specified above except to the extent that the person(s)/company(ies) have already taken action on the disclosure provisions contained in this document. This authorization indicates your approval to release the protected health information obtained in connection with this authorization to the State of Connecticut Insurance Department for regulatory purposes.

_____ Date: _____

(Signature of Parent/Legal Guardian, if Minor is under the age of 16)

OR

_____ Date: _____

(Signature of Minor over the age of 16)

List of all providers I would like to release information to the Office of Healthcare Advocate:

Please initial inside grey box for each provider listed below:

Initial	
	Name:
	Address:
	Telephone:

Initial	
	Name:
	Address:
	Telephone:

	Name:
	Address:
	Telephone:

	Name:
	Address:
	Telephone:

	Name:
	Address:
	Telephone:

	Name:
	Address:
	Telephone:

	Name:
	Address:
	Telephone:

	Name:
	Address:
	Telephone:

In addition to the other protections listed throughout this document, any information released to the Office of the Healthcare Advocate (OHA) is subject to the following notices:

Psychiatric Information:

In the event that information released to OHA constitutes confidential psychiatric information protected under Connecticut law:

This information has been disclosed to OHA from records whose confidentiality is protected by state law. State law prohibits OHA from making further disclosure of it or of using it for any purpose other than that indicated above without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law.

Drug and Alcohol Abuse Information:

In the event that information released to OHA is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records regulations:

This information has been disclosed to OHA from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit OHA 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 42 C.F.R. Part 2. 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.