STATE OF CONNECTICUT
DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

CAPITOL REGION MENTAL HEALTH CENTER
500 VINE STREET – HARTFORD, CONN. 06112
TELEPHONE 860 – 297-0923

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

THIS IS A LEGAL DOCUMENT AND WILL NOT BE HONORED UNLESS IT IS COMPLETED IN FULL

Patient/Client (Last Name, First Name) _____ Date of Birth _____ MPI # _____ Last 4 digits of SS# _____

I, the undersigned, authorize the above named facility to: ☐ **DISCLOSE information to** ☐ **OBTAIN information from**

Name of Person _____ Name of Organization _____

Address: _____

City _____ State _____ Zip Code _____

I understand that this authorization is voluntary and that information to be released/obtained may include Medical, Psychiatric, Substance Abuse and/or HIV/AIDS treatment information unless otherwise specified:
Limitations/Restrictions_____

Purpose of Release: (*Check Appropriate Boxes*)
☐ Evaluation/Treatment ☐ Benefit Determination
☐ Placement/Referral ☐ Case Management Coordination
☐ Other (*specify*): _____

Information to be released/obtained: (*Check Appropriate Boxes*)
☐ Psychiatric Evaluation ☐ Medical History and Physical Exam ☐ Diagnostic Reports (*specify*): _____
☐ Psychosocial History/Assessment ☐ Discharge/Transfer Summary _____
☐ Psychological Evaluation ☐ Medication Records
☐ Treatment Plans ☐ Other (*specify*):_____

Dates of Treatment Covered by this Request:
☐ All prior episodes of care, through discharge from present episode of care
☐ Limited to the following Dates(s):
_____

This authorization, if not cancelled, will expire:
_____
Date (*not to exceed 12 months*), event or condition upon which this authorization expires. *If blank, authorization will expire 12 months from date of signature below*.

I understand that refusal to sign this authorization form will in no way affect my right to obtain present and future treatment, except where disclosure of such communications and records is necessary for treatment. I also understand that I may revoke this authorization at any time by signing the "**CANCELLATION/REVOCATION**" section below, except to the extent that action has been taken in reliance on it. I further understand that the confidentiality of psychiatric, substance abuse and HIV/AIDS records are protected under State and Federal Laws and cannot be disclosed without my written authorization unless otherwise provided for by law. The information disclosed by this facility pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal law. I understand that this authorization is voluntary and that information to be released/obtained may include Medical, Psychiatric, Substance Abuse and/or HIV/AIDS treatment information unless otherwise specified above.

_____ _____
Signature of Patient/Client/Authorized (Legal) Representative* Date

A copy of this authorization will be provided to the Patient/Client/Authorized Representative as requested.

CANCELLATION/REVOCATION:_____ _____
Signature of Patient/Client/Authorized (Legal) Representative* Date

*If this form has been signed by the patient's/client's Authorized (Legal) Representative, a copy of the legal appointment must be attached. ☐ Conservator/Guardian ☐ Executor of Estate ☐ Other (*specify*): _____

☐ **File only - Ongoing verbal communication** ☐ Send attention to: _____

NOTE: Confidentiality of psychiatric, drug and/or alcohol abuse and HIV records is required and no information from these specific records shall be transmitted to anyone else without written consent or authorization as provided under Connecticut General Statutes, Chapters 899c and 368x and Federal Regulations 42 CFR 2. These laws prohibit you from making any further disclosure without specific written consent of the person to whom it pertains. A general authorization for the release of information is NOT sufficient for this purpose.