CVH-514
Rev. 4/03

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES
CONNECTICUT VALLEY HOSPITAL
Addiction Services Division

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION FOR REIMBURSEMENT

I hereby authorize Connecticut Valley Hospital (Addiction Services Division) and the State of Connecticut Financial Services Center to disclose and/or release Medical, Psychiatric, AIDS/HIV, Psychological Testing, Drug and Alcohol Information, if applicable, from my hospital record to be used for the purpose of obtaining reimbursement for my care to:

- ☐ State Administered General Assistance Program (SAGA), ABH
- ☐ Medicare, QUALIDIGM
- ☐ Medicaid, Department of Social Services
- ☐ Other (*Specify name of other insurance*): _____

The confidentiality of this record is required under Connecticut Statutes Chapters 368x and 899 and under CFR 42 Part 2 of the Federal Register. This information shall not be transmitted to anyone else without written consent or other authorization as provided in these Statutes. I may revoke this authorization at any time except to the extent that action has been taken in reliance thereon. Consent will automatically expire one year from the date of signature.

Patient Name: _____ Date: _____

Signature: _____

Witness: _____ Date: _____

CANCELLATION:

_____ _____

Patient/Legal Representative Signature Date: