

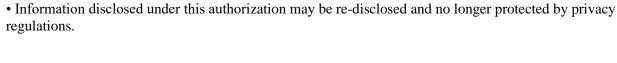
Manisha Juthani, MD Commissioner



Ned Lamont Governor Susan Bysiewicz Lt. Governor

# STATE OF CONNECTICUT DEPARTMENT OF PUBLIC HEALTH AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name:	Date of Birth:	
I authorize the <b>State of Connection</b> below regarding the patient identified	cut, Department of Public Health (DPH) to disclose the health in fied above to:	nformation indicated
Name:		
	Fax#	
	☐ Verbal ☐ Pick-up ☐ Review ☐ FAX	
· -	s authorized to disclose (check all that apply)	
$\square$ Laboratory Reports $\square$ Menta	l health records*   Substance abuse records**	
☐ HIV related information*** ☐	Other	
(specify)		
This disclosure or use is for the f	following reason:	
☐ Medical ☐ Legal ☐ Disabili	ity $\square$ Insurance $\square$ Individual's request $\square$ Other	
Expiration: This authorization ex	pires on	
(specify date or event)		_
	revoke this authorization at any time by notifying DPH in writing; to information that has already been released in response to this au	





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



- DPH will not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this authorization.
- 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 & signa	ture) Date
Relationship to patient: $\square$ Self $\square$ Parent $\square$ Guardian $\square$ Conse	ervator $\square$ Executor of Estate $\square$ Power of
Attorney U Other	
Name of Witness	Signature of Witness
If signed by the legal Representative attach appropriate documentati	on 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.



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