STATE OF CONNECTICUT – DEPARTMENT OF SOCIAL SERVICES

W-303A
(Rev. 05/15)

Permission to Share Medical Information

Name of DSS Client _____**Client ID #**_____**or SSN#**_____

I authorize _____ **to disclose the information indicated below** to the
(Name of medical provider)
Connecticut Department of Social Services (DSS) and its agent, Colonial Cooperative Care, LLC.
I authorize this disclosure for the following purpose(s):

_____
(If you do not wish to state a purpose, you may write "at my request")

Type of information Medical Provider is authorized to disclose (check all that apply):

☐ Protected health information (other than mental health, substance abuse and HIV-related records)

☐ Mental health records*

☐ Alcohol and/or drug treatment records** ☐ HIV-related information***

☐ other _____

- I understand that my refusal to sign will not affect my ability to obtain services or benefits from the medical provider.
- I understand that I may revoke this authorization at any time by notifying the medical provider, in writing, except if a disclosure has already been made in reliance on it.
- I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by privacy regulations.
  This authorization expires one year after the date it is signed.

X_____Date_____ _____
Patient Signature or person with legal authority to sign for patient Printed Name of Person Who Signed
(Attach copy of designation as conservator/ power of attorney/ guardian, if applicable)

Note to Recipient of Information:

* **Mental Health Records:** The confidentiality of psychiatric records is required under chapter 899 of the Connecticut General Statutes. This material shall not be transmitted to anyone without written consent or other authorization as provided in the aforementioned statutes.

** **Alcohol and/or Drug Treatment Records:** This information has been disclosed to you from records protected by Federal confidentiality rule (42 CFR Part 2). The Federal rules prohibit you 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 CFR 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.

*** **HIV Related Information:** This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose.

Persons who are deaf or hard of hearing and have a TTD/TTY device can contact DSS at 1-800-842-4524.
Persons who are blind or visually impaired can contact DSS at 1-860-424-5040.