STATE OF CONNECTICUT
WORKERS' COMPENSATION COMMISSION

AUTHORIZATION TO OBTAIN AND/OR DISCLOSE HEALTH INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____
(Please Print Name) (Required)

I, the undersigned, authorize _____
(Hospital or Provider)

To disclose, in writing, protected health information (PHI) to:

_____
(Person or Entity to whom information is to be disclosed)

And its attorneys and representatives. The PHI to be disclosed is relevant medical records and reports relating to my medical treatment/consultations/examinations and/or diagnostic procedures performed at the above-referenced medical facility. I understand that I have the right to copy or inspect the PHI to be disclosed as permitted under Federal HIPAA law and state law.

I authorize the following PHI to be obtained/disclosed from my medical records:
Dates of Service **or** Date range _____
Body part(s) _____

PROTECTED RECORDS

REQUIRED: Please initial the lines below to indicate you authorize the release of the protected information specified, even if the categories do not necessarily apply to the patient's medical records.

(Initial _____) Alcohol, Drug or Substance Abuse Treatment Records
(Initial _____) HIV Testing & Related Information
(Initial _____) Reproductive Healthcare Services
(Initial _____) Mental or Behavioral Health Treatment Records
(Initial _____) Genetic Testing

I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION.

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION. In order to revoke this authorization, I may, at any time, send written notification to the above-named hospital/provider. I understand that my revocation of this authorization is ineffective to the extent that the above-named hospital/provider has relied on this authorization to disclose PHI relating to me.

I UNDERSTAND THAT PHI DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE REDISCLOSED BY THE PERSON OR ENTITY I HAVE IDENTIFIED ABOVE AND MAY NO LONGER BE PROTECTED FROM DISCLOSURE TO OTHERS BY FEDERAL OR STATE LAW. I understand that the above-named hospital/provider may not condition my treatment on whether I provide authorization for the requested use or disclosure.

IF THE PHI THAT IS DISCLOSED UNDER THIS AUTHORIZATION IS CONFIDENTIAL HIV/AIDS RELATED INFORMATION, PSYCHIATRIC OR OTHER PROTECTED MENTAL HEALTH INFORMATION, ALCOHOL OR DRUG ABUSE RELATED INFORMATION, OR REPRODUCTIVE HEALTH INFORMATION, THE RECIPIENT MAY BE PROHIBITED FROM REDISCLOSING THAT INFORMATION UNDER FEDERAL OR CONNECTICUT LAW.

I understand that if this disclosure contains information relating to HIV, behavioral health, alcohol, drug and/or substance abuse treatment, the following shall apply: This information has been disclosed to you from records whose confidentiality is protected by law. Federal regulations (Title 42 CFR Part 2) and Connecticut General Statutes (Ch. 368x) prohibit 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 such regulations. A general authorization for the release of psychiatric or substance abuse information is NOT sufficient for this purpose.

I UNDERSTAND THAT I HAVE THE RIGHT TO DETERMINE A DATE OR EVENT WHEN THIS AUTHORIZATION EXPIRES.
Unless otherwise revoked, this authorization will expire on the following date/event: _____. If I fail to specify an expiration date/event, this authorization will expire six (6) months from the date signed.

I further understand that federal HIPAA law does not require me to provide an authorization in this form as the purpose of this form relates to a Workers' Compensation matter. However, I understand that as a practical matter, my authorization may facilitate the processing and administration of my claim for Workers' Compensation benefits.

My signature below indicates that I have read and understand this authorization and its terms.

Signature of Patient/Parent/Legal Representative Date Relationship to Patient

Revised: October 1, 2025