AUTHORIZATION FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. This form summarizes the anticipated use of information about you for which an Authorization is required. Collins Medical Associates 2, P.C. provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

For:_____[patient name]DOB: _____

Specific description of the information to be used or disclosed:

_____

_____

Specific purpose of disclosure:

_____

_____

Individuals who may disclose this information: _____

_____

Individuals who may receive the disclosed information: _____

_____

Expiration date or expiration event of this authorization: _____

_____

Special Records: Include the following medical records if such information is included in your records. Checking the boxes does not show that such information exists.

( ) _____ Initial Include drug and alcohol abuse records.

( ) _____ Initial Include mental health records.

( ) _____ Initial Include HIV/AIDS – related records.

( ) _____ Initial Include sexual abuse/assault and domestic violence counseling records.

The above mentioned protected health information may be subject to re-disclosure by the party receiving the information and thus may no longer be protected by the privacy rules.

By signing this form, you authorize the Practice to use and disclosure protected health information about you for the reasons mentioned above. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit your revocation to the Privacy Officer of the Practice.

If you refuse to sign this Authorization, we may not withhold treatment, except that (a) we may withhold research-related treatment if you refuse to supply authorization for the use or disclosure of your information for such research, and (b) we may withhold treatment that is being furnished

solely for purposes of creating protected health information for disclosure to a third party (such as a life insurance company exam or school physical), where disclosure to the third party requires execution of this Authorization.

This authorization was signed by: _____

By:_____
Patient or Representative Signature

Date:_____/ /____

Basis for Representative's Authority to Sign for Patient _____
(e.g. parent, guardian, legal representative)

PLEASE PROVIDE THE PATIENT WITH A COPY OF THIS FORM WHEN SIGNED FOR THEIR RECORDS

Disclaimer to party receiving records:

Records containing HIV-related information—
This information has been disclosed to you from records protected by Connecticut law. Connecticut law prohibits 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 is authorized by the Confidentiality of HIV-Related Information Act. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Records containing psychiatrist records—
"The confidentiality of this record is required under Chapter 899 of the Connecticut general statutes. This material is not to be transmitted to anyone without written consent or other authorization as provided by the aforementioned statutes."

Records containing drug and alcohol abuse records—
The confidentiality of these records are protected by the Federal Drug Abuse Prevention, Treatment and Rehabilitation Act (21 U.S.C. 1175 and 42 CFR Part 2), if the treatment was in any way provided or funded, directly or indirectly, by federal agencies. This federal law prohibits release of such drug or alcohol abuse information without the patient's consent, except in emergencies or upon court