Eastern Connecticut
Psychological
Associates, LLC

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# Authorization for the use and disclosure of protected health information

**This is a legal document and will not be honored unless completed in full.**

_____ _____ _____
**Patient name (Last, First)** **Date of Birth** **Last 4 digits of SS#**

**I, the undersigned, authorize the above agency to: ___Disclose information to ___Obtain information from**

**Name of Person_____ Name of organization_____**

**Address:_____**

**City:_____ State_____ Zip Code_____**

**I understand that this authorization is voluntary and that information to be released/obtained may include medical, psychiatric, substance abuse and/or HIV/AIDS treatment information unless otherwise specified:**
**Limitations/Restrictions:_____**
**Purpose of Release:** **___Evaluation/Treatment** **___ Benefit Determination**
**___Referral** **___Legal/probation**
**___Appeal of Social Security Disability benefits**
**___Other (please explain)_____**

**Information to be released/obtained:**
**___Psychiatric Evaluation** **___Medical history/physical exam** **___Psychological Evaluation**
**___Discharge/transfer Summary** **___Medication records** **___Treatment plans**
**___Emergency Room report** **___Photographs, video, digital recordings**
**___other (specify)_____**
**This consent will end one year from the date the form is signed unless I indicate an earlier date or event here:**
**Date____/_____/_____ Or specific event_____**
MM DD YYYY

I understand that refusal to sign this authorization form will in no way affect my right to obtain present and future treatment, except where disclosure of such communications and records is necessary for treatment. I also understand that I may revoke this authorization at any time by signing the "Cancellation/Revocation" section below, except to the extent that action has been taken in reliance on it. I further understand that the confidentiality of psychiatric, substance abuse and HIV/AIDS records are protected under State and Federal laws and cannot be disclosed without my written authorization unless otherwise provided for by law. The information disclosed by this agency pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal Law. I understand that this authorization is voluntary and that information to be released/obtained may include Medical, Psychiatric, Substance Abuse and/or HIV/AIDS treatment information unless otherwise specified above.

_____ _____
Signature of patient/authorized (legal) representative Date

A copy of this authorization will be provided to the patient/Authorized Representative as requested.

CANCELLATION/REVOCATION:_____ _____
Signature of patient/Authorized Representative Date

Note: Confidentiality of psychiatric, drug and/or alcohol abuse and HIV records is required and no information from these specific records shall be transmitted to anyone else without written consent or authorization as provided under Connecticut General Statues, Chapters 899c and 368x and Federal Regulations 42 CFR 2. These laws prohibit you from making further disclosure without the specific written consent of the person to whom it pertains. A general authorization for the release if information is NOT sufficient for this purpose.