The Village
Where real change happens

Phone: 860-236-4511, ext. 3780
Fax: 860-296-6014

Date Completed: _____

AUTHORIZATION TO OBTAIN / DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Subject to the statements printed on the back, I, the undersigned patient or legal representative, hereby authorize the use and disclosure of Protected Health Information (PHI) including, if applicable, information related to the diagnosis or treatment of mental illness, drug and/or alcohol abuse and HIV related information. The information authorized may be obtained /disclosed in verbal, written, and/or electronic format. **Program:** _____ **Clinician:**_____

_____	_____	_____
Patient Name	**Date of Birth**	**Client Number** (if known)

For closed cases only: indicate dates of service and / or Program this request relates to _____

Your Authorization

I hereby authorize the Village for Families and Children and its staff to: (Check one or both)

☐ **Disclose** (Share/send) information about the client's medical, service records
☐ **Obtain** (Receive/request) information about the client's medical, service records

To/From (e.g., M.D., school name, attorney) of third-party organization or individual:

_____ Name	_____ Tel #
_____ Agency/Organization	_____ Fax#
_____ Address (street, city, zip)	_____ E-mail

The purpose of this disclosure is:
☐ Evaluation and Treatment ☐ Legal ☐ Disability ☐ Insurance ☐ Education ☐ Other _____

Information to be obtained or disclosed
☐ Communication (verbal or written) with other providers regarding treatment or care

Documents:
☐ Treatment Plan ☐ Assessment ☐ Educational Records ☐ Psychiatric Evaluation ☐ Psychological Assessment
☐ Discharge/Transfer ☐ Medications ☐ Other: _____

Method of Disclosure(s): ☐ Any method **or**: ☐ Verbal ☐ Mail ☐ Pick-up ☐ E-mail* ☐ fax # _____
* E-mailed information provided by the Village will be encrypted requiring recipient to log-in to encryption site and establish a password.

- This authorization will be valid through: _____or one year from the date below if no date is indicated. I understand that I may revoke this authorization at any time by notification in writing to the address below. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations.
- I understand that my treatment or continued treatment by The Village is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it.
- I understand that I may inspect the information to be used or disclosed and that there may be a charge for copies.
- The parent or legal guardian must sign this authorization if the patient is a minor (under age 18) or has a legal guardian.

As the authorized client representative, I understand and give my consent (check type and sign when client is a minor under 18)
☐ Parents have joint custody ☐ Mother only ☐ Father only ☐ Power of Attorney ☐ DCF Committed
☐ Guardianship order ☐ Legal Representative or Executor ☐ Order of Protective Custody (emergency basis only)

_____	_____	(____) _____
Signature of Client or Guardian	**Date**	**Phone #**

Rev. 10/4/2019

Note to Recipient of Information:

HIV Related Information

In the event that information release constitutes confidential HIV related information protected under Connecticut Law (CT General Stature 368x): 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 said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Psychiatric Information

In the event that information released constitutes confidential psychiatric information protected under Connecticut Law (CT General Statute Chapter 899c): 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 or of using it for any purposes other than that indicated above without the specific written consent by the person to whom it pertains, or as otherwise permitted by said law.

Drug and Alcohol Abuse Records

In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records Regulations: This information has been disclosed to you from records protected by federal confidentiality rules (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.

Authorization may be sent to:

The Village for Families & Children, Inc
Attn: Medical Records
331 Wethersfield Avenue, Hartford, CT 06114
Phone: 860-236-4511, extension 3780 Fax: 860-296-6014