Community Mental Health Affiliates, Inc.

Release of Information Form

This authorization must be completed if a client's medical record is being sent to a third party. This authorization form is required to be completed in full, allowing the exchange of PHI. All areas that are "Required" must be completed, any missing information will delay any requests and/or prevent CMHA from communicating with the requesting agency. If "Other" is selected there must be information written in specifying the additional information. Please review the authorization for accuracy and use the MM/DD/YYYY format for all dates. This authorization form must be signed by the client or the legal representative, (parent, conservator or legal guardian.)

Medical Records Contact Info

Direct Line: 860-348-2310

Fax Line: 860-827-3473

Attn: Medical Records
233 Main St.
New Britain, CT 06051
P-860-348-2310
F-860-827-3473

HIPAA Authorization to Obtain and/or Release Protected Health Information from another Facility or Individual

I authorize Community Mental Health Affiliates to obtain and/or disclose/release health information including, if applicable, information relating to the diagnosis or treatment of mental illness, drug and/or alcohol abuse and confidential HIV related information regarding client.

Client Name:_____ Date of Birth:_____ MRN # _____

I authorize Community Mental Health Affiliates: (REQUIRED: Select all that apply)

☐ to obtain PHI from the following Facility/Person ☐ to release PHI to the following Facility/Person

Community Mental Health Affiliates	**The information may be disclosed to, obtained from, and used by the following Facility / Agency / Person: (REQUIRED)**
Address:	**Name:**
City, State, Zip:	**Address:**
Phone Number:	**City, State, Zip:**
Fax Number:	**Phone Number:**
Attention:	**Fax Number:**

Purpose of disclosure or use is for the following reason: (REQUIRED: Select one)

☐ At the request of the client or legal representative ☐ Medical ☐ Payment ☐ Legal ☐ Treatment

☐ Other (please specify): _____

The dates of service and the type(s) of information to be used or disclosed as follows: (REQUIRED: Select all that apply)

☐ Discharge Summaries ☐ Medical History, Examination, Treatment ☐ Psychiatric Evaluations ☐ Drug/Alcohol Use, Assess, Treat Urine Drug Screen
☐ Medication Management Progress Notes ☐ HIV/AIDS Testing ☐ Psychological Testing ☐ Mental Health Progress Note
☐ Intake Assessment ☐ Other Type of Information (Must specify): _____

Dates of Treatment to be released / obtained: (REQUIRED: Select one)

☐ All Dates of Service
☐ Specified Dates: **Start Date:**_____ **End Date:**_____

This authorization will be **valid for the episode of treatment**. This authorization will expire 30 days from date of discharge from the agency. I understand that I may cancel this authorization at any time by notifying my CMHA Health Information Management Department (provide address and name) in writing, but if I do it will not have any effect on actions that CMHA took in reliance on the authorization while it was in effect.

I understand that I am not required to sign this authorization as a condition of treatment, payment, enrollment, or eligibility for benefits, except where disclosure of the information is necessary for treatment or payment.

I understand the information disclosed under this authorization potentially could be re-disclosed by the recipient, subject to applicable law, and no longer protected by the HIPAA privacy regulations.

If signed by the Legal Representative, indicate your relationship to the client below:
☐ Conservator ☐Health Care Representative ☐ Parent ☐ Executor of Estate ☐ Next of Kin ☐ Power of Attorney ☐ Guardian

Print Name: _____
Signature: _____ **Date**: _____

Note: The confidentiality of psychiatric, alcohol, drug and HIV related records is required by Connecticut General Statutes and/or Federal Regulations 42 CFR, part 2. This information shall not be disclosed to anyone else without written consent or other authorization as provided on the Connecticut General Statues and/or Federal Regulation 42 CFR, part 2. A general authorization for the release of medical information is not sufficient for this purpose. This authorization may be revoked by me at any time, expect to the extent that action has been taken in reliance thereon. This authorization expires 30 days from date of discharge from agency, unless expressly revoked earlier.

[A copy of this Authorization must be provided to the patient or representative at the time of signature] **rev 6-30-16**