ProHealth PHYSICIANS

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

I, _____, authorize ProHealth Physicians/_____ to release:

□my health information (DOB __/__/____)

□my minor child/children's health information: Child's name _____ DOB __/__/____
Child's name _____ DOB __/__/____
Child's name _____ DOB __/__/____

□ the health information of the patient for whom I am the authorized representative:
Patient's name_____ DOB __/__/____

as described below, to the following RECIPIENT**:**

_____

Recipient Name Street Address City, State, ZIP Code

I request that the information to be used or disclosed consist of the following (*if this is an authorization for the use or disclosure of psychotherapy notes, it may not be combined with an authorization for the use and disclosure of any other type of health information except other psychotherapy notes)*. **CHECK ALL THAT APPLY**:

(A charge of up to $0.65 per page copied is generally allowable under Connecticut state law.)

☐ Complete Medical Record (including records from prior providers) ☐ Only Medical Record from ProHealth Providers

☐Medical History, Evaluation Records	☐ X-ray Reports	☐Laboratory Reports
☐ Hospital Records Including Reports	☐ Immunizations	☐ Prescription Data
☐ Consultation Documentation	☐ Surgical Reports	☐Summary of Record

☐ Other (Specify):_____

□ I specifically authorize that any sensitive information regarding HIV/AIDS, substance abuse (alcoholism or drug abuse) and/or mental health may be used by or disclosed to the above referenced recipients.

□ I do not authorize the release of HIV/AIDS, substance abuse and/or mental health information.

It is my understanding that the information to be used or disclosed will be used for the following purposes (CHECK ALL THAT APPLY):

☐ At the request of the individual signing this authorization (no purpose need be specified)

☐ Additional Medical Care ☐ Change of Provider ☐ Insurance Eligibility/Benefits ☐ Legal Investigation or Action

☐ Other (Specify): _____

I understand that the disclosed information may be redisclosed in accordance with law and may no longer be protected by the federal privacy standards. Further, I understand that if the authorized recipient is not a provider, health plan, or clearinghouse required to comply with federal privacy standards, the information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.

INDIVIDUAL'S RIGHTS RELATING TO THIS AUTHORIZATON:

I understand that I must be provided with a copy of this form if I choose to sign it. I understand that I am under no obligation to sign this form and that ProHealth Physicians may not condition treatment, payment, or enrollment/eligibility for benefits on my decision to sign this form. I understand that I may revoke this Authorization by notifying ProHealth Physicians in writing of my revocation. To obtain information on how to revoke my Authorization or to receive a copy of my revocation, I am to contact ProHealth Physicians' Privacy Official at 4 Farm Springs Road, Farmington, CT 06032, Attention: Privacy Official. I am aware that my revocation will not be effective as to uses and/or disclosures of the health information that the person(s) and or organization(s) listed above have already made in reliance on this Authorization.

EXPIRATION DATE: This Authorization is valid until _____. I have had an opportunity to review and understand the content of this Authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

_____ _____

PATIENT'S OR REPRESENTATIVE'S SIGNATURE **PRINTED NAME**

_____ _____

REPRESENTATIVE'S RELATIONSHIP (IF APPLICABLE) **DATE**

Revised January 2009