WATERSTONE HEALTH
32 Wall Street, Madison●400 Bayonet St, New London●3190 Whitney Ave, Hamden
Telephone: 203-245-0412 Fax:203-427-0441

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

THIS IS A LEGAL DOCUMENT AND WILL NOT BE HONORED UNLESS IT IS COMPLETED IN FULL

_____ _____ _____

Client/Patient Name **Date of Birth** **Last 4 digits of SS#**

I, name above, authorize the above named facility to: DISCLOSE information to OBTAIN information from

Name of Person_____ Name of Organization_____

Address_____ Phone_____

City_____ State_____ Zip Code_____ Fax_____

I understand this authorization is voluntary and that authorization to be released/obtained may include Medical, Psychiatric, Substance Use and or HIV/AIDS treatment information unless otherwise specified:
Limitations/Restrictions_____

Purpose of Release: (*Check appropriate boxes)*
- □ Evaluation/Referral
- □ Placement/Treatment
- □ Continuity of Care
- □ Other (*specify)*: _____

Information to be released/obtained: (*Check appropriate boxes)*
- □ Psychiatric Assessment
- □ Medical History and Physical Exam
- □ Psychosocial History/Assessment
- □ Discharge/Transfer Summary
- □ Medication Records
- □ Other (*specify)* _____

Dates of Treatment Covered by this Request:
- □ All prior episodes of care, through discharge from present episode of care
- □ Limited to the following Date(s):

_____

This authorization, if not cancelled, will expire:

_____
Date (*not to exceed 12 months),* event or condition upon which this expires. (*If blank authorization will expire 12 months from date of signature below.*

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 communication and records is necessary for treatment. I also understand 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 use and HIV/AIDS records are protected under State and Federal laws and cannot be disclosed without my written authorization unless otherwise provided for by the law. The information disclosed by this facility 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 Use and/or HIV/AIDS treatment information unless otherwise specified above.

_____ _____
Signature of Client/Patient/Authorized (Legal) Representative* Date

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

CANCELLATION/REVOCATION:_____ _____
Signature of Client/Patient/Authorized (Legal) Representative* Date

*If this form has been signed by the client's/patient's authorized representative, a copy of the legal appointment must be attached Conservator/Guardian Executor of Estate Other (*specify):* _____

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 Statutes, Chapter 899c and 368x and Federal regulations 42 CFR 2. These laws prohibit you from making other disclosure without specific written consent of the person to who it pertains. A general release of information is NOT sufficient for this purpose.