Easterseals
Authorization to Disclose/Obtain Health Information

I, the undersigned patient or legal representative, hereby authorize the use and disclosure of health information including, if applicable, information relating to the diagnosis or treatment of mental illness, drug and/or alcohol abuse and HIV related information.

Patient Name:_____ **Date of Birth:**_____

AUTHORIZATION TO DISCLOSE:	**AUTHORIZATION TO RELEASE:**
I authorize Easterseals to disclose (release) health information to: Name:_____ Facility:_____ Address:_____ _____ Telephone #: _____ Fax#: _____ **Method of Disclosure: (check all that apply)** ❑ Mail ❑ Verbal ❑ Electronically ❑ Pick-up ❑ Review	I authorize _____ to release health information to: EASTERSEALS Agency _____ Street Address _____ City, State, Zip code _____ Telephone # / Fax #

The dates of service and the type(s) of information to disclosed or released are as follows:
Date(s) of Treatment:_____
❑ Evaluations ❑ Progress Reports ❑ Discharge Summary ❑ Entire Record ❑ Billing Records ❑ Other_____

The purpose of this disclosure or use is for:
❑ Medical ❑ Legal ❑ Disability ❑ Insurance ❑ At the request of the patient ❑ Other_____

- This authorization will be valid for a period of one year from the date below. I understand that I may revoke this authorization at any time by completing an Authorization Revocation Form. 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 Easterseals, 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 or copy the information to be used or disclosed. I understand there is 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 and has demonstrated proof of identity.

_____ _____ _____
Signature of Patient or Legal Representative **Date** **Witness**

Relationship to patient: ❑ **Self** ❑ **Parent** ❑ **Guardian** ❑ **Conservator** ❑ **Executor of Estate** ❑ **Power of Attorney**
❑ **Other** _____

NOTICE

HIV RELATED INFORMATION: In the event that information released constitutes confidential HIV related information protected under Connecticut Law: 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: 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 purpose 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 (42CFR 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.