AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Name ____ Date of Birth ______________________

I hereby authorize communication between the following providers, including release of protected health information:

Name: ___________________________ Name: ______________________________

Address: ___________________________ Address: ______________________________

___________________________ ______________________________

___________________________ ______________________________

I authorize the following methods of communication: [ ] phone [ ] verbal [ ] e-mail [ ] fax

The dates of service and the type(s) of information to be used or disclosed are as follows:

Dates of Treatment: ____

Type of Information to be disclosed:
[ ] Medical/Clinical/Psychological/Psychiatric Information [ ] Treatment plans, background information
[ ] Psychological / neuropsychological / psychosocial assessment. [ ] Other ____________________________

The purpose of this disclosure or use is for the following reason:
[ ] Medical/Psychological treatment or follow-up [ ] Legal [ ] Disability [ ] Request of patient
[ ] Other ____

I understand that a copy of this authorization will be as valid as the original. This authorization will remain in effect until ____________________unless withdrawn. I understand I have the right to withdraw this authorization at any time by sending written notification to Spectrum Psychotherapy Centers, but that this withdrawal will not affect actions taken prior to the withdrawal. I understand that refusal to grant authorization will not jeopardize my right to obtain present or future treatment except where the disclosure of such information is necessary for treatment, obtaining payment for treatment, or certain health care administrative operations. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of this information and no longer protected by the HIPAA Privacy Rule if the recipient is not a health care provider or health plan.

____ _______________
Signature of Patient or Representative (Relationship to Patient) Date

____ _______________
Witness Date

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/PSYCHOLOGICAL INFORMATION
In the event that information released constitutes confidential psychiatric/psychological 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 (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.