University of Connecticut
Health Center
John Dempsey Hospital
UCONN Medical Group

Authorization to Obtain and/or Disclose Health Information

1. I hereby authorize UConn Health Center to disclose and/or obtain my individually identifiable health information as described here to the person/organization named below. I understand that this authorization is voluntary and that it ***may include information relating to AIDS, HIV infection, behavioral health services/psychiatric care, treatment for alcohol and/or drug abuse.***

PATIENT'S NAME:				DATE OF BIRTH:
ADDRESS:				E-MAIL ADDRESS:
CITY:	STATE:	ZIP CODE	TO#:	PHONE NUMBER:

2. Dates of Service ______________________________

3. Information: ☐ to be disclosed or ☐ to be obtained (PLEASE CHECK INFORMATION NEEDED BELOW)
   - ☐ Discharge Summary
   - ☐ History & physical examination
   - ☐ Consultation reports
   - ☐ Emergency Dept. record
   - ☐ Radiology films
   - ☐ Radiology reports
   - ☐ Inpatient record, including Psychiatric Inpatient
   - ☐ Laboratory tests
   - ☐ Entire record (Consideration will be given to releasing the entire record ONLY when subsections of the record will not serve the intended purpose of the disclosure.)
   - ☐ Rehabilitation Dept. notes
   - ☐ Outpatient clinic notes – Describe which clinic here: ______________________________
   - ☐ University Dentists notes
   - ☐ Dental Clinic notes
   - ☐ Outpatient Behavioral Health notes (including Partial Hospital notes)
   - ☐ Other (please specify): ______________________________

4. Please ***DO NOT*** release the following information: ______________________________

5. I am requesting that this information **be disclosed** ☐ / **obtained** ☐ for the purpose of (*i.e. Legal reasons, continued care, insurance, another medical opinion, Worker's compensation, research, personal use, Social Security*):

x

6. Name of the person(s)/organization(s): **to whom the disclosure is to be made** ☐ or **from whom the information is to be obtained** ☐
   If the disclosure is made to or obtained from more than one person/organization ***for the same purpose***, more than one entry may be made below.

NAME			PHONE NUMBER
ADDRESS			
CITY	STATE	ZIP	

NAME			PHONE NUMBER
ADDRESS			
CITY	STATE	ZIP	

7. **If authorization is to obtain information, please provide information to**:
   UNIVERSITY OF CONNECTICUT HEALTH CENTER Provider Name: ______________________________
   Department: ______________ Mail Code: __________ Phone Number: ____________ Fax: ____________
   Address: ______________________________ Zip code: __________

8. Name and relationship to patient of individual authorized to pick up record(s) being released from the facility:
   ____

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9. I understand this authorization may be revoked **in writing to the Director of Health Information Management** at any time, except to the extent that action has already been taken in reliance on this authorization. This authorization shall automatically expire 6 months from the date of signature unless otherwise specified in the space provided here.
   DATE OF EXPIRATION: ______________________.

10. I understand that I may inspect and copy the information to be used and disclosed under this authorization and that I may receive a copy of this signed authorization form. **There may be a fee associated with producing the records, not to exceed what Connecticut State law authorizes.**

11. UConn Health Center, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

12. I understand that UConn Health Center may not condition treatment on the provision of this authorization except in cases of research-related treatment protocols or studies being conducted by outside third parties through UConn Health Center. In such cases, specific authorization for the research-related treatment protocols/studies must be signed as a condition of participation. In cases where UConn Health Center is requested by a third party to create health information solely for the purpose of sharing that information with the party that requested it, I understand that I must sign this authorization.

13. **Notice to Recipients:** As the recipient of this information, you may use this information only for the stated purpose. You may disclose this information to another party ONLY:
    - *With written authorization from the patient or his or her legal representative;*
    - *As required or authorized by state and / or federal law; or*
    - *If urgently needed for the patient's continued care.*

    If this disclosure contains information relating to HIV, behavioral health, alcohol or drug abuse education, training, treatment, rehabilitation, or research, the following shall apply: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (Title 42 CFR Part 2) and Connecticut General Statutes (Ch. 368x) prohibit 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 such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

14. **Notice to Individual Requesting the Disclosure:**
    Your signature below indicates that you understand that if the organization authorized to receive the information is not a health care provider or health plan, and the information disclosed is NOT protected by Title 42 CFR Part 2 and Ch. 368x, then the released information may no longer be protected by the HIPAA Federal Privacy Regulations.

____
Printed Name of Patient

______________________________________ ____________________
Signature of Patient or Legal Representative Date/Time

______________________________________ ____________________
Printed name of Legal Representative * Relationship to Patient
* A copy of the personal representative's legal authority to act on behalf of the patient is attached.

______________________________________ ____________________
Signature of Individual Picking up Record Relationship to Patient

For Office Use Only

Sign & Date	
Check identification	
Date records needed by:	
Charges:	
Copy of Authorization was provided to patient	

NOTES: **(When using this form in the Laboratory, a physician signature is required to disclose results to anyone.)

______________________________________ ____________________
Physician Signature Date/Time