First Choice Health Centers
For All Your Health Care Needs

94 Connecticut Boulevard
East Hartford, Connecticut 06108
F: 860-528-5180 Ph: 860-528-1359

Authorization for Release of Protected Health Information

I authorize any member of the medical staff of First Choice Health Centers or any of its employees or representatives to use and/or disclose my protected health information (PHI) as provided below. I understand that I may revoke this Authorization, except to the extent that the entity has already taken action in reliance on this Authorization. The written revocation letter needs to be sent to the Medical Records Department of First Choice Health Centers. The provision of treatment will not be conditioned on the completion of this Authorization. I understand that once the PHI listed below is used or disclosed as set forth in this Authorization, such information is subject to re-disclosure and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that a fee may be charged for this service for copying and first class postage related to the use/disclosure of my health information under this authorization.

Patient Information

Last Name: **First Name:** **Middle Initial:** _____

Address: **Telephone:** **Date of Birth:**

I, the undersigned authorize First Choice Health Centers, Inc. to ☐ **DISCLOSE and/or** ☐ **RECEIVE** protected health information to/from the below indicated entity or individual:

Name:_____

Organization Name:_____

Street Address_____

City:_____ **State:**_____ **Zip Code:**_____

Telephone: (_____)_____ **Fax: (_____)**_____

How may your records be released? ☐ **Electronic (CD)** ☐**Paper**

☐ **copies by mail** ☐ **copies by fax (up to 10 pages, otherwise mailed)**

OR ☐ **copies to be picked up - BY WHOM? Name:** _____**(ID WILL BE REQUIRED)**

I authorize the release of my records for the following purpose [MUST *check one*]

☐ **At the request of the patient or the patient's legal representative** ☐ **Other (please specify)** _____

My authorization is for the use and disclosure of the following records:

☐ Entire Medical Record
☐Most Recent Physical Exam
☐Immunization Records
☐Lab Results
☐X-rays and Other Images
☐Dental Record
☐ Other:_____

I understand that state law prohibits the use and/or disclosure of the PHI listed below unless specifically authorized by me. I understand that such information will not be used or disclosed unless I indicate by initialing below.

For alcohol and drug abuse disclosures provide an explicit description of the substance use disorder information that may be disclosed.

☐ Alcohol or Drug Abuse (initials) _____
Description: _____
☐ AIDS or HIV (initials) _____
☐ Mental Health/Psychiatric Disorders (initials) _____
☐ Psychotherapy Notes (A separate authorization form is required to request psychotherapy notes and cannot be combined with any other authorization.)

If you are not requesting an entire medical record; please indicate the dates of service:

Between: _____/_____/_____ ending on date:_____/_____/_____

NOTICE TO RECIPIENT OF INFORMATION RELEASED UNDER THIS AUTHORIZATION:

If substance abuse information has been released:

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 in this record that identifies a patient as having or having had a substance use disorder directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed 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 with regard to a crime any patient with a substance use disorder, expect as provided at §§ 2.12(c)(5) and 2.65.

If confidential HIV related information has been released:

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

Patient or Patient's Personal Representative with *legal authority* to act for Patient must sign *and* date this Authorization for it to be valid

Expiration Date: Unless I revoke this authorization or provide a different expiration date below, this Authorization will expire twelve (12) months from the date of execution. Other expiration date: _____

_____ _____

Signature of Patient or Patient's Personal Representative Date

RELATIONSHIP TO PATIENT (circle one) : Self Mother Father Legal Guardian Conservator Other (please specify) _____

For Office Use Only (only if all elements are present implying compliance will a request be honored)

☐ **Two Patient Identifiers**
☐ **Description of Information**
☐ **Disclosing Entity**
☐ **Recipient**
☐ **Copy to Individual**
☐ **Purpose**
☐ **Expiration Date**
☐ **Signature**
☐ **Drug/Alcohol/HIV Disclosures**
Compliance Met: _____(process)
Denied (Not Compliant):_____(deny