Connecticut Institute of Behavioral Health Inc.
495 Gold Star Hwy Ste 220 Groton, CT 06340
(P)860-326-5405 (F) 860-326-5571

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Client Name: ____D.O.B.: _________ SSN: _____-_____-_____

I understand that the information to be exchanged may contain protected substance abuse, psychiatric, and confidential HIV-related information (Protected Health Information).

I authorize Connecticut Institute of Behavioral Health Inc., to:

☐ **Release** Protected Health Information to: *and/or* ☐ **Obtain** Protected information from:

Individual / Organization Name

Name: ____
Address:____ City: ______________ State: ______ Zip: ________
Phone: ____ Fax:____

The Protected Health Information that may be used or disclosed includes: [Check all that apply]

☐ Complete Medical Record
☐ Admission Assessment
☐ Progress Notes
☐ Discharge Summary
☐ Mental Health Information
☐ Drug/Alcohol related information
☐ HIV/AIDS related information
☐ Medications
☐ All episodes
☐ Specific: ______________________________________
☐ Other(specify): _______________________________

The information released under this authorization will be used for the following purposes: [Check all that apply]

☐ Assess for Intake Purposes
☐ Coordinate Care
☐ Provide Treatment
☐ Refer for Services
☐ Review History
☐ Other: ____

I understand this information will be used to provide comprehensive and coordinated services. I agree that a copy of this authorization will be as valid as the original. I understand this consent will expire as designated below, but in no case will it expire later than one year from the date of my signature. I give this consent freely and voluntarily and understand that refusal to grant authorization will not prevent me from utilizing services upon acceptance to Connecticut Institute of Behavioral Health Inc.

I understand that I may revoke this consent at any time prior to the release of the above information, once disclosed to others, may be re-disclosed to entities not subject to the Health Insurance Portability and Accountability Act of 1966 (HIPAA), and therefore, may no longer be protected by the HIPAA. The confidentiality of this record is required under chapter 899 of the Connecticut General Status as well as Title 42 of the United States Code. This material cannot be transmitted to anyone without your written authorization, as provided for in these statutes.

Print Name:____Date:___________________________

Signature of Client or Authorized Legal Representative: ____