Authorization for Release of Protected Health Information

Connecticut Back Center
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As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Connecticut law, this practice may not use or disclose your individually identifiable health information without your authorization except as provided in our Notice of Privacy Practices. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purposes for the disclosure.

I hereby authorize **CONNECTICUT BACK CENTER** to use and disclose health information concerning:

Patient Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

City: _____

State: _____

Zip Code: _____

Description of health information to be used or disclosed (If this is an authorization for the use or disclosure of psychotherapy notes, it may not be combined with an authorization for the use and disclosure of any other type of health information except other psychotherapy notes. If there are to be specific dates of service disclosed, please specify these dates. If all dates of service are to be disclosed, please check box next to “All Dates of Service”:

☐ All Dates of Service
☐ Specify Dates of Service _____

Medical Information to be released:
☐ Office Notes
☐ Lab/Radiology Results
☐ All Medical Records
☐ Other _____

By checking below, I indicate agreement with the following statement:

☐ I understand that this health information may include HIV-related information and/or -information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am authorizing such information to be disclosed.

This health information may be disclosed to and used by:
(Name and address of person/entity to receive and use the health information)

Name: _____

Address: _____

City: _____

State: _____

Zip Code: _____

Phone #: _____ Fax #: _____

I understand that I may revoke this authorization at any time by notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt.

I understand that, if the recipient of the information is not a health care provider or health plan covered by the Federal Privacy Rule, the information used or disclosed as described above may be re-disclosed by the recipient and no longer protected by the Privacy Rule. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.

This authorization is effective now and will remain in effect for one year or until _____
(expiration date or event). I understand that I have the right to receive a copy of this authorization.

Signature: _____

Date: _____

Print Name: _____

If not signed by the patient, please indicate relationship:
_____