EASTERN CONNECTICUT EAR, NOSE & THROAT, P.C.

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____ , hereby authorize personnel to use and disclose the following designated health information:

_____ All records, INCLUDING all below
_____ Psychotherapy notes
_____ HIV or AIDS records
_____ Any information when a minor has requested confidential treatment, including billing information
_____ Other: _____

_____ All records, EXCEPT items checked below
_____ Psychiatric communications
_____ Substance abuse treatment

Disclose this information only to authorized individuals at:

PHYSICIAN/PRACTICE NAME: _____

ADDRESS: _____ CITY: _____STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

Disclose this information for the following purposes:

_____ At my request
_____ Pre-employment examination
_____ Long-term care insurance
_____ New health insurance policy for an existing patient

_____ Independent medical examination
_____ Life insurance
_____ Disability insurance
_____ Other: _____

This authorization is effective immediately and will remain in effect until _____

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. Connecticut General Statute allows up to 30 days to complete this record release.

1. 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.
2. I understand if I do not sign this form: a health plan may not enroll me or make me eligible for benefits; my physician will not perform the expert, employment, life insurance or other physical or medical evaluation which would otherwise be performed solely for the purpose of disclosure of a third party; my right to obtain present or future treatment for psychiatric disabilities will not be jeopardized, except where disclosure of the information is necessary for treatment.
3. 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.
4. 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 redisclosed by the recipient and no longer protected by the Privacy Rule. 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.
5. I understand that I have the right to receive a signed copy of this authorization.
6. This authorization must be filled out completely to be valid.
7. 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.

Your signature indicates your agreement with the above listed conditions.

Signature: _____ Printed Name: _____

Date of Birth: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____ Date Signed: _____

36 Watson Street, Willimantic, CT 06226 860.456.0287
79 Wawecus Street, Norwich, CT 06360 860.886.6610
914 Hartford Turnpike, Waterford, CT 06385 860.537.1903
Fax: 860.456.8382
www.EasternCTENT.com

If not signed by patient, please indicate relationship and reason: _____

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