UCONN HEALTH

(Patient Identification Label)

Name:

Medical Record/DOB:

Authorization for the Disclosure of Protected Health Information

PATIENT INFORMATION

Patient Name: _____ Date of Birth: ___/___/___

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: (_____) _____ Email: _____

INFORMATION TO BE DISCLOSED TO

I authorize UConn Health to disclose protected health information as designated below to:

Name: _____ Phone Number: (_____) _____

Address: _____ City: _____ State: _____ Zip Code: _____

Relationship: _____

Purpose: ☐ At the request of the individual named ☐ Other (Specify): _____

INFORMATION TO BE RELEASED

This authorization to disclose protected health information to the individual named above applies to:

☐ All past, present and future periods *OR* From: _____ To: _____

The following is a specific description of the health information I authorize to be disclosed:

☐ Abstract of Medical Record	☐ Billing/Payment	☐ Progress Notes	☐ Laboratory Results
☐ Complete Record	☐ Operative/Procedure Report	☐ Dental Notes	☐ Pathology Results
☐ History and Physical Exam	☐ Radiology	☐ Dental Xrays	☐ Immunizations
☐ Emergency Room Records	☐ Radiation Oncology	☐ Clinic/Office Note	☐ PT/OT/Speech Note
☐ Consultation Report	☐ Radiology Film	☐ Medical Images	☐ Discharge Summary
☐ Echocardiogram/EKG	☐ UConn Health Pharmacy Services, Inc.		
☐ Other: _____			

I hereby also authorize the disclosure of the following specially protected information by initialing the specific categories:

(INITIAL _____) Alcohol, Drug or Substance Use Treatment (INITIAL _____) Behavioral Health Treatment

(INITIAL _____) HIV/AIDS Testing and/or Treatment (INITIAL _____) Genetic Testing

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I understand that I am under no obligation to sign this form, and that UConn Health may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits based on my decision to sign this authorization. I may change my mind and cancel (revoke) this authorization at any time by providing a written statement of revocation to the Director, Health Information Management, 263 Farmington Ave, Farmington, CT 06030. I am aware that my revocation will not be effective until received by the Health Information Management Department and will not be effective regarding the uses and/or disclosures of my health information that UConn Health has made prior to receipt of my revocation statement. I understand that I will be provided with a copy of this authorization upon request. I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the UConn Health, Health Information Management Department.

REDISCLOSURE NOTICE: I understand that information used or disclosed based on this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy standards.

EXPIRATION DATE: This authorization is valid until (indicate date or event): _____

_____ _____
Signature of Patient or Authorized Individual** Date

_____
Printed Name of Patient or Authorized Individual**

Relationship to Patient:

☐ Self ☐ Parent ☐ Legal Guardian ☐ Healthcare Representative ☐ Conservator

☐ Executor/Administrator of Estate ☐ Power of Attorney ☐ Other Authorized Representative: _____

***A copy of the authorized representative's legal authority to act on behalf of the patient must be attached.*

MAIL	UConn Health Health Information Management Release of Information 263 Farmington Avenue, MC2260 Farmington, CT 06030
OTHER	**Phone:** (860) 679-2787 **Fax:** (860) 679-1273 **Email:** PatientROIRequests@uchc.edu *(For Patient Use Only)*

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NOTICES

Minors

If a minor has the authority to consent to a particular health care service without parental or other consent, or if the parent or guardian has agreed to confidentiality between the provider and the minor, the minor has sole authority to exercise his or her rights under HIPAA. For example, under appropriate circumstances, minors may consent to their own HIV testing and treatment, treatment for alcohol and drug abuse, outpatient mental health treatment, or treatment of sexually transmitted diseases without parental consent. In cases where the minor provides his or her consent, parents and others will not be recognized as personal representatives and so will not have access to the minor patient's protected health information (PHI) related to the treatment.

Psychiatric Records and Communications

In the event that information released constitutes privileged psychiatrist-patient communications: "The confidentiality of this record is required under chapter 899 of Connecticut General Statutes. This material shall not be transmitted to anyone without the written consent or other authorization as provided in the aforementioned statutes." (Conn. Gen. Stat. § 52-146i)

Substance Use Disorder Records

In the event that information released constitutes confidential Substance Use Disorder records: 42 CFR part 2 prohibits unauthorized use or disclosure of these records. A general authorization for the release of medical or other information is NOT sufficient to meet the required elements of written consent to further use or redisclose the record (42 CFR 2.31).

HIV Related Information

In the event that information released constitutes confidential HIV-related information protected under Connecticut Law: "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 law. A general authorization for the release of medical or other information is NOT sufficient for this purpose." Conn. Gen. Stat. § 19a-585(a).

Reproductive Health Care or Gender-Affirming Health Care Services

State law prohibits the disclosure of any protected health information related to reproductive health care services or gender-affirming health care services for the purposes of any civil action or any proceeding preliminary thereto or in any probate, legislative or administrative proceeding, without the written consent of the person to whom it pertains, except in limited circumstances as outlined in the law. As the patient, or the patient's conservator, guardian, or other authorized legal representatives, you have the right to withhold such written consent. (Conn. Gen. Stat. § 52-146w and 52-146x)