Town of Hamden Authorization Form for Disclosure/Release of Protected Health Information (PHI) General Health Information/Drug/Alcohol/Psychiatric/HIV Related Information

Date:_____

Patient: _____ Date of Birth: _____ Social Security No: _____

Address: _____ Medical Record No: _____

1. I hereby authorize Town of Hamden to release information from the health record of the above-named

patient concerning injuries sustained on _____to:
(date of injury/treatment)

_____

(Name, Address and Relationship of Person Authorized to Receive Records)

2. Purpose for such information is: _____
(Reason for request)

3. Requested material: _____
(Medical report, accident report)

4. Date of Incident: _____

5. This form serves the dual purpose of a general authorization for the release of protected health information and a specific authorization for the release of information protected by state and federal confidentiality laws and regulations. The information to be released may contain information pertaining to psychiatric, psychological, drug and/or HIV or AIDS testing, diagnosis or treatment.

6. I understand my right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and submit this to the department that maintains my requested information. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand authorizing the disclosure of this health information is voluntary. I need not sign this authorization to ensure treatment, payment or healthcare operations. I understand I may inspect or copy the information to be used or disclosed according to state and federal law, and as stated in the Privacy Notice of this facility. I understand information once released from this facility may not be protected by federal confidentiality rules and carries with it the potential for an unauthorized re-disclosure.

7. Event or date upon which authorization will expire: immediately upon disclosure of above-referenced documents

8. A photocopy of this authorization shall have the same force and effect as the original.

_____ _____
Signature of Patient or Legal Representative If Legal Representative, specify relationship

The patient is a minor, _____ years of age
The patient is unable to authorize because: _____

_____ Date: _____
Signature of Witness