ANCHOR HEALTH

**Anchor Health - Hamden**
2200 Whitney Ave, Suite 290
Hamden, CT 06518

**Anchor Health - Stamford**
30 Myano Lane, Suite 16
Stamford, CT 06902

# AUTHORIZATION TO PERMIT RELEASE OF HEALTH INFORMATION

The Authorization to Release Protected Health Information is for Anchor Health Initiative Corp. *("Anchor Health")* patients. This form is used to release your protected health information as required by federal and state privacy laws.

## *Patient Information:*

| | | | |
|---|---|---|---|
| **Date of Request:** | *Month:* | *Day:* | *Year:* |
| **Last Name:** | **First Name:** | | **MRN:** *(staff-use)* |
| **Legal Name:** *(if different)* | **Date of Birth:** | *Month:* | *Day:* | *Year:* |

## *Sender Information:*

**I hereby authorize information from my health record be released from:**

☐ Anchor Health - Hamden ☐ Anchor Health - Stamford ☐ Other *(specify below)*

***Or individual, entity, or organization not listed above:***

| | | |
|---|---|---|
| **Name:** | | **Title:** |
| **Organization/Department:** *(if applicable)* | | |
| **Address:** | | |
| **City:** | **State:** | **Zip Code:** |
| **Phone:** | | **Fax:** |

## *Reciever Information:*

**I am requesting information be sent to:**

☐ Anchor Health - Hamden ☐ Anchor Health - Stamford ☐ Other *(specify below)*

***Or individual, entity, or organization not listed above:***

| | | |
|---|---|---|
| **Name:** | | **Title:** |
| **Organization/Department:** *(if applicable)* | | |
| **Address:** | | |
| **City:** | **State:** | **Zip Code:** |
| **Phone:** | | **Fax:** |

**The records and information I authorize to be released shall include:** *(check the appropriate boxes)*

☐ All medical records, including information/records received from other health care providers or other third parties; **or**

☐ Only the following information from my medical records, including information from other health care providers or others:

- ○ My record for treatment of: *(specify diagnosis or symptom)* _____
- ○ Laboratory results
- ○ Medication/prescription records
- ○ Other: *(specify record type)* _____

## *Sensitive Information*

**The following information will not be released without specific authorization. To authorize release, please initial next to the information to be released.**

**Mental health information:** _____ **Substance use disorder information:** _____

**HIV-related information:** _____

**Dates of treatment covered by this Authorization:** *(check the appropriate box and provide information, if applicable)*

☐ All prior episodes of care ☐ Limited to the following dates: _____

☐ Ongoing communication: I authorize ongoing oral or written information exchange.

**I authorize release of information for the following purposes:** *(check the appropriate box and provide information, if applicable)*

☐ Transfer/continuation of health care ☐ Care coordination ☐ Legal representation/proceedings ☐ Payment

☐ Other: *(please specify)* _____

**Date, event, or condition when this Authorization will expire:** _____

## *Acknowledgements*

**Please review carefully.**

***I understand that:*** *(a) Anchor Health may not condition my treatment based on whether I sign this Authorization; (b) I have the right to revoke this Authorization, in writing, except to the extent action has been taken in reliance on this Authorization; and (c) the information/records used or disclosed by this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws; provided that if I am authorizing the release of HIV-related, mental health, or substance abuse treatment information/records, the recipient is prohibited from further disclosing such information/records without my specific written consent unless otherwise permitted under federal or state law.*

***I have read this Authorization or had it explained to me, and I understand and agree to its contents.***

| | |
|---|---|
| **Name of Patient:** *(PRINTED)* | **Date:** |
| **Signature:** | |
| **Name of Person Signing:** *(PRINTED)* | |

*If not signed by patient, please check off the basis for your authority to sign this Consent:*

☐ Parent of minor ☐ Guardianship order ☐ Power of attorney ☐ Conservator of person ☐ Other: _____

*If this authorization includes the release of information for services obtained by a minor without parental consent, as permitted under state law (e.g., STD or HIV-related treatment), the minor must sign if a parent/guardian signed above:*

| | |
|---|---|
| **Name of Minor/Client:** *(PRINTED)* | **Date:** |
| **Signature:** | |

***Please note that this is a legal document and will not be honored unless it is completed in full.*** *There may be charges associated with producing authorized records. Information on applicable charges is available at our offices.*

## *Notices to Individual, Entity, or Organization Receiving Disclosed Protected Health Information:*

***For authorization for release of HIV-related information:*** This information has been disclosed to you from records protected by Connecticut law. Connecticut law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by Connecticut law. A general authorization for the release of medical or other information is not sufficient for this purpose.

***For authorization for release of any mental health or substance use disorder information (received by Anchor Health from third-party mental health or substance use providers):*** The confidentiality of this information is required under chapter 899 of the Connecticut general statutes. This information shall not be transmitted to anyone without written consent or other authorization as provided in chapter 899 of the Connecticut general statutes.

***For authorization for release of mental health information (received by Anchor Health from third-party mental health providers):*** This information has been disclosed to you from records whose confidentiality is protected by state law. State regulations prohibit you from making any further disclosure of this information without the prior written consent of the person to whom it pertains.

***For authorization for release of substance use disorder and/or treatment information (received by Anchor Health from Part 2 programs or other lawful holders):*** This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12 (c)(5) and 2.65.