

Pick-Up Date \_\_\_\_\_

**The Charlotte Hungerford Hospital  
HIPAA Authorization for the Release of Medical Information**

Date \_\_\_\_\_ Radiology # \_\_\_\_\_ Medical Record # \_\_\_\_\_

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Phone # \_\_\_\_\_

I authorize The Charlotte Hungerford Hospital to release my medical records, including a copy of my entire mental health record, including psychiatric and drug information, and information regarding my AIDS/HIV status, treatment or testing, emergency room records, nursing notes, laboratory results, pathology reports, x-ray reports, films, all consent forms, and a copy of the bill for services rendered, to:

DR. \_\_\_\_\_

I authorize the disclosure of the following diagnostic studies and reports: \_\_\_\_\_

\_\_\_\_\_

The information/films will be used/disclosed for the following purpose: \_\_\_\_\_

\_\_\_\_\_

1. Should I fail to return to The Charlotte Hungerford Hospital original films in the same condition they were released to me, I and my heirs and assigns hereby waive any rights or causes of action I may have against The Charlotte Hungerford Hospital for retention and maintenance of this specific part of my medical record.

2. This authorization will expire in 6 months and may be revoked by me, at any time, in writing except to the extent that action has been taken in reliance thereon. This authorization is valid unless and until it is revoked and properly presented to our records office. (Authorization must be currently dated within the past 6 months and dated after the information you are requesting, per Hospital Policy.)

3. I understand that if the person or entity that receives the information is not a health care provider or health care plan covered by the federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

4. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.

5. If any of the information to be released constitutes a psychiatric communication or a communication with a psychologist, or any other mental health worker, this release will serve as my written release of that information. I understand that my refusal to grant consent for this release of mental health information will in no way jeopardize my right to continue to obtain treatment, except where disclosure is necessary for treatment or permitted by law. I understand that no psychotherapy notes may be disclosed by my signing this authorization, and that a separate authorization would be required for the release of psychotherapy notes.

6. If any of the information to be released relates to treatment for alcohol or drug abuse, I understand that such information is subject to the requirements of Part 2 of Title 42 of the Code of Federal Regulations which prohibits the further release of such information without my consent, as referenced in the federal regulations, or as otherwise permitted by law.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Or Signature of Parent, Guardian, or Legal Representative: \_\_\_\_\_

Specify Relationship: \_\_\_\_\_

**\* Recipient of Materials See Reverse Side of Form**

**TO THE RECIPIENT OF THESE MATERIALS:**

If the information disclosed constitutes confidential HIV/AIDS information, it is protected under Connecticut law as follows:

“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 said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.”

Any oral disclosure shall be accompanied or followed by the above notice within 10 days. See Connecticut General Statutes section 19a-585.

**PSYCHIATRIC COMMUNICATIONS:** If the released material contains confidential psychiatric communications, as designated in C.G.S. sections 52-146d through 52-146i, inclusive, please note the following:

“The confidentiality of this record is required under Chapter 899 of the Connecticut general statutes. This material shall not be transmitted to anyone without written consent or other authorization as provided in the aforementioned statutes.”

A copy of the consent form setting forth any limitations shall accompany the disclosure.

**DRUG & ALCOHOL TREATMENT:** No person, hospital, treatment facility or department of health may disclose or permit the disclosure of the identity, diagnosis, prognosis or treatment of any patient in a treatment for drug and/or alcohol abuse that would be in violation of federal or state law. In the event that the records contain information regarding drug and/or alcohol abuse treatment, please note the following legal requirements and prohibitions:

“This information has been disclosed to you from records protected by federal and state confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.”

See Connecticut General Statute section 17a-688.