Community Health & Wellness
Our Family – Taking Care of Yours

CHWC
469 Migeon Ave
Torrington Ct 06790
Phone 860-489-0931
Fax 860-489-3325

AUTHORIZATION TO OBTAIN AND DISCLOSE HEALTH INFORMATION

I _____, _____, _____ authorize
PLEASE PRINT – Name of Patient **Date of Birth** **Phone Number**

❑ **Send information to:**

PLEASE PRINT – Name of Medical Facility or Agency

Address

❑ **Get information from:**

PLEASE PRINT – Name of Medical Facility or Agency

Address

INITIAL next to the information to be disclosed:

Medical		Dental		Behavioral Health		GYN	
Complete Record		**Complete Record**		**Complete Record**		**Complete Record**	
Patient Summary		Patient Summary		Patient Summary		Patient Summary	
Progress Notes		Procedure Notes		Initial Diagnostic Evaluation		Progress Notes	
Physical Exam		X-Rays		Psychiatric Evaluation		Annual Exam	
Lab Results				Treatment Planning		Lab Results	
Diagnostic Imaging Reports				Progress Notes		Diagnostic Imaging Reports	
Immunizations				Discharge Summary		Pap Smear Results	

Dates of treatment:	❑ **All Dates**	***or***	❑ **Date Range From:**	**To:**

Other specific information to be released _

Any information you do NOT want disclosed? _

INITIAL next to each item below if you specifically authorize the release of health information relating to the testing, diagnosis or treatment for:

HIV/AIDS		**Substance Use Disorders**		**Mental Health/Psychiatric Disorders**	

This information will be released for the following purpose (any other use is prohibited)

❑ Disability ❑ Legal ❑ Moving out of state ❑ Specialist Care ❑ To obtain Social Security Card
❑ Personal ❑ Transferring to New PCP ❑ Other: _____

- I understand that the records to be released may contain information pertaining to HIV-related, psychiatrics, drugs and or alcohol abuse treatment, and may contain other confidential information. I understand that the confidentiality of such records is protected under State and Federal Law and cannot be disclosed without my authorization unless otherwise provided by law.
- I understand that refusal to grant consent to release information will not jeopardize my right to obtain treatment, payment or eligibility for benefits, except where disclosure is necessary for the treatment.
- I also understand this consent is subject to revocation at any time by signing the "**CANCELLATION/REVOCATION**" section below, except to the extent that action has been taken in reliance thereon. Federal Law provides that once a release is signed for a Probation or Parole it may not be revoked. Federal law may subject to re-disclosure by the recipient and no longer protect the information disclosed by this institution. 42 CFR part 2 prohibits unauthorized disclosure of these records.
- This Authorization shall expire in 180 days after the date appearing below or 180 days after patient's final treatment.

Date:_____ **Signature:**_____ **Relationship:**_____
Patient/Client or Authorized legal representative/Guardian

Date:_____ **Signature:**_____ **Relationship:**_____
Witness

CANCELATION/REVOCATION:_____ **Date:**_____
Signature of Patient/Client/Authorized Legal Representative

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