BEHAVIORAL HEALTH CONSENT FOR RELEASE AND/ OR EXCHANGE OF INFORMATION

NORWALK COMMUNITY HEALTH CENTER

_____ _____ _____ _____

Patient/Client (Last Name, First Name) Date of Birth PT ID# Last 4 digits SS#

I, the undersigned authorize NCHC to: ☐ **DISCLOSE** ☐ **OBTAIN information**

Agency / Person: (circle one) **Relationship:**_____

List name_____ Phone: _____Fax:_____

Address: _____ _____

City _____ State _____ Zip Code _____

I understand that this authorization is voluntary and that the information to be released/ obtained may include Medical, Psychiatric, Substance Abuse and/or HIV/AIDS treatment information unless otherwise specified:
Limitations/Restrictions _____

Purpose of Release:

(*Check Appropriate Boxes)*

☐ Evaluation/Treatment ☐ Benefit Determination

☐ Placement/Referral ☐ Case management Coordination

☐ Other (*specify*): _____

Information to be released /obtained: *(Check Appropriate Boxes)*

☐ Psychiatric Evaluation
☐ Psychosocial History/ Assessment
☐ Psychological Evaluation
☐ Treatment Plans
☐ Diagnostic Reports (*specify*): _____
☐ Medical History and Physical Exam
☐ Discharge/Transfer Summary
☐ Medication Records
☐ Other (*specify*): _____

Dates of Treatment Covered by this Request:

☐ All prior episodes of care, through discharge from present episode of care

☐ Limited to the following Date(s):

_____

This authorization, if not cancelled, will expire:

_____

Date (*not to exceed 12 months)*, event or condition upon which this authorization expires. *If blank, authorization will expire 12 months from date of signature below.*

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_____	_____	_____	_____
Patient/Client (Last Name, First Name)	Date of Birth	PT ID#	Last 4 digits SS#

I understand that refusal to sign this authorization form will in no way affect my right to obtain present and future treatment, except where disclosure of such communications and records is necessary for treatment. I also understand that I may revoke this authorization at any time by signing the **"CANCELLATION/REVOCATION"** section below, except to the extent that action has been taken in reliance on it. I further understand that the confidentiality of psychiatric, substance abuse and HIV/AIDS records protected under State and Federal Laws and cannot be disclosed without my written authorization unless otherwise provided for by the law. The information disclosed by NCHC pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by the Federal law. I understand that this authorization is voluntary and that information to be released/ obtained may include Medical, Psychiatric, Substance Abuse and/or HIV/AIDS treatment information unless otherwise specified above.

_____

Signature of Patient/Client/Authorized (Legal) Representative*

_____

Date

A copy of this authorization will be provided to the Patient/Client/Authorized Representative as requested.

CANCELLATION/REVOCATION: _____ _____

Signature of Patient/Client/Authorized (Legal) Representative* Date

*If this form is signed by the patient's/client's Authorized (Legal) Representative, a copy of the legal appointment must be attached.

☐ Conservator/Guardian ☐ Executor of Estate ☐ Other (*specify*):_____

NOTE: Confidentiality of psychiatric, drug and/or alcohol abuse and HIV records is required and no information from these specific records shall be transmitted to anyone else without written consent or authorization as provided under Connecticut General Statues, Chapters 899c and 368x and Federal Regulations 42 CFR 2. These laws prohibit you from making any further disclosure without specific written consent of the person to whom it pertains. A general authorization for this release of information is NOT sufficient for this purpose.