

Reliance Health, Inc.
40 Broadway, Norwich, CT 06360
Telephone: (860) 887-6536 Fax: (860) 885-1970
e-mail: PrivacyOfficer@reliancehealthinc.org

Authorization for Release of Information

Name: _____ **Date of Birth:** _____

Address: _____ **Social Security No.:** X X X-X X- _____

Subject to the statements printed on the back, I hereby authorize Reliance Health, Inc. and/or any Reliance Health program to use my medical information, including, if applicable, protected drug and/or alcohol abuse, confidential HIV-related and psychiatric information (“Protected Health Information”) for the purposes described below, and to:

RELEASE Protected Health Information to: _____
(individual or organization name)

and/or

OBTAIN Protected Health Information from: _____
(individual or organization name)

The nature and extent of Protected Health Information to be used or disclosed: *[Check applicable information]*

All Health Information (during the period from **first date of admission** to **present**)

All Health Information (during the period from ___/___/___ to ___/___/___)

Progress Notes _____ History of Medication Evaluation & Management

Assessments _____ Integrated Recovery Plan

Other _____

Limitations on Disclosure _____

This Authorization and information released under it are to be used for the specific purpose(s) of: *[check applicable]*

Assess for Intake purposes

Refer for services

Coordinate care

Judicial Proceedings (i.e. child protective services)

Service Coordination and planning

Other: _____

I understand that I may revoke this Authorization at any time by signing the Cancellation/Revocation section below, but such revocation will not effect any actions taken before the revocation was received. This Authorization expires one year from the date of signature. I give this Authorization freely and voluntarily. I understand that I may refuse to sign this Authorization and that my refusal to sign this Authorization will not prevent me from obtaining services.

I understand that under applicable law recipients of my Protected Health Information may not be subject to the federal privacy laws. Consequently, information disclosed under this authorization may be subject to further disclosure by the recipient and may no longer be protected by the federal privacy regulations. Such information, however, may continue to be protected for recipients that are subject to state or federal confidentiality laws or contractual confidentiality obligations. I understand that I am entitled to a copy of this authorization form. I agree that a copy of this authorization will be as valid as the original.

Signature/Authorized Legal Representative*

Date signed

Authorization expiration date
(not to exceed 1 year)

CANCELLATION/REVOICATION: _____
Signature/Authorized Legal Representative*

***Note:** If you are signing as the legally authorized representative, please indicate your relationship to the individual. If applicable, a copy of this legal appointment must be attached (this should demonstrate your authority to consent to health care for the individual):

Any information released by a program to authorized persons is subject to the following notices:

Psychiatric Information:

In the event that information released constitutes confidential psychiatric information protected under Connecticut law:

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.

Drug and Alcohol Abuse Information:

In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records regulations:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR 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 CFR 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.

HIV-Related Information:

In the event that information released constitutes confidential HIV-related information protected under Connecticut law:

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.