FAIRFIELD COUNTY HEALTHCARE ASSOCIATES, P.C.
d.b.a. PEDIATRIC HEALTHCARE ASSOCIATES
(203) 452-8322

- ☐ Commerce Park, 4699 Main Street, Bridgeport, CT 06606
- ☐ 50 Unquowa Place, Fairfield, CT 06824
- ☐ 4 Corporate Drive (Suite 290), Shelton, CT 06484
- ☐ 2876 Main Street, Stratford, CT 06614
- ☐ 15 Corporate Drive, Trumbull, CT 06611

AUTHORIZATION FOR RELEASE OF PHYSICAL AND MENTAL HEALTH RECORDS

Patient Name: ____________________________________ DOB: __________________

I, _________________________________, hereby authorize Fairfield County Healthcare to release medical health records for the above patient including a copy of the complete and entire mental health record, all records for his/her care and treatment, including psychiatric and drug information, and information regarding HIV/AIDS status, treatment or testing, emergency room records, nursing notes, laboratory results (individually copied), pathology reports, x-ray reports and films to:

Name ____

Address ____

This information is needed for the following reason:

____

The specific information I wish to have released is (include dates of treatment):

____

If any of the information to be released constitutes a psychiatric communication or a communication with a psychologist, this release will serve as a written release of that information. I understand that I may refuse to grant the consent for this release of psychiatric/psychological information, and such a refusal will in no way jeopardize my right to continue to obtain treatment for my child, unless disclosure is otherwise permitted by law or necessary for treatment.

If any of the information to be released relates to treatment for alcohol and/or drug abuse, I understand that there are special requirements for my consent to release as found in Part 2 of Title 42 of the C.F.R., which prohibits the further release of that information without my consent, as referenced in the federal regulations, or as otherwise permitted by law.

TO THE RECIPIENT OF THESE MATERIALS:

In the event that any of the disclosed information includes HIV/AIDS information, this is protected under state law as follows:

> "This information has been disclosed to you from records whose confidentiality is protected under 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. See Connecticut General Statute section 19a-585.

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

> "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 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 and/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 disclosed to you is protected by state and federal law, specifically as outlined in Part 2 of Title 42 of the C.F.R. Federal law prohibits you from making further disclosure of this information unless the written consent of the person about whom the information pertains is obtained. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Federal law also restricts any use of this information to criminally investigate or prosecute any alcohol and/or drug abuse patient." See Connecticut General Statute section 17a-688.

I understand that I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a sixty (60) day period from the date it is signed.

____ __________________________

Signature of Patient or (his/her parent or guardian) Date

Name: __________________________________

Address: ________________________________

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Phone: __________________________________