AUTHORIZATION FOR DISCLOSURE OF PATIENT INFORMATION

189 Storrs Road, PO Box 260
Mansfield Center, CT 06250
Phone: (860) 456-1311

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

I authorize Natchaug Hospital to:

☐ **Disclose** protected health information from my medical record, or the medical record of my child/ward/ Conserve, either orally or in written form, **to** the individual(s), agency or organization specified below.

and/or

☐ **Request the disclosure** of protected health information from my medical record, or the medical record of my child/ward/conserve, either orally or in written form, **from** the individual(s), agency or organization specified below.

Name(s): _____

Address *(Street, City, State)*: _____

Telephone: _____ **Fax:** _____

Date or date range for information covered by this authorization: _____

This authorization is restricted to information about:

- ☐ **Psychiatric or mental health** assessment, diagnosis, treatment, recommendations, dates of treatment.
- ☐ **Alcohol and/or drug abuse** assessment, diagnosis, treatment, recommendations, and dates of treatment.
- ☐ **Medical** testing, assessment, immunizations, diagnosis and/or treatment.
- ☐ **Psychological testing** (intelligence, achievement, aptitude, personality and/or diagnostic).
- ☐ **School records** (attendance, performance, assignments, assessments, disciplinary and counseling records).
- ☐ **HIV/AIDS** testing, diagnosis, status and/or treatment.
- ☐ Other *(specify):* _____

This authorization is further restricted to: ☐ Discharge/aftercare information only.

☐ Other *(specify)*: _____

This information is to be used only for the following purpose(s):

- ☐ To facilitate planning for, and the delivery of, **mental health and/or chemical dependency treatment services**.
- ☐ To facilitate the delivery of mental health and/or chemical dependency **case management services**.
- ☐ To facilitate the **involvement of family/significant other(s)** in treatment activities and planning for aftercare services.
- ☐ To coordinate the **delivery of medical services** with medical service providers.
- ☐ Other *(specify):* _____

I understand that this authorization is valid for one year from the date of signing, or until such time as it is revoked by me by means of a written request for revocation presented to the Department of Health Information Management at Natchaug Hospital. I acknowledge that any such revocation cannot and will not apply to any information released or obtained by Natchaug Hospital through actions taken prior to the date and time at which a written request for revocation is presented to the Department of Health Information Management.

By signing this form, I acknowledge that information disclosed to any person, agency or organization, other than a healthcare provider or other entity covered by applicable state and/or federal privacy regulations, may be redisclosed by that person, agency or organization without my consent and without my being informed of the disclosure.

I understand that I may refuse to sign this authorization and that any such refusal on my part will not affect my ability, or the ability of my child/ward/conservee, to obtain services from Natchaug Hospital.

I understand that I may inspect or copy any information disclosed and/or obtained through the implementation of this authorization.

_____ _____ _____

Signature of Patient **Date** **Time**

_____ _____ _____

Signature of Legal Guardian/Custodian **Date** **Time**

If signed by a representative, describe below the representative's authority to act on behalf of the patient. _____

See reverse for rules about release of information for minors.

_____ _____ _____

Signature of Witness **Date** **Time**

Date ☐ disclosed ☐ requested: _____ ☐ Mail ☐ Fax ☐ Hand ☐ Oral _____

HIM or Other Staff

NATCHAUG HOSPITAL AUTHORIZATION FOR DISCLOSURE OF PATIENT RECORDS
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TO THE RECIPIENT OF THESE MATERIALS:

HIV/AIDS information: In the event that any of the information disclosed or requested includes information about the patient's testing, status and/or treatment for HIV/AIDS, please note that:

> "This information has been disclosed to you from records whose confidentiality is protected under state [Connecticut General Statutes, Title 19a, Chapter 368x, §§19a-583 through 19a-585, inclusive] and federal law [the U.S. Health Insurance Portability and Accountability Act of 1996]. These laws 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."

Psychiatric information: If the information disclosed or requested includes information about the patient's psychiatric testing, status, diagnosis and/or treatment, or includes information about communications between the patient and the patient's mental health treater(s), please note that the information constitutes confidential psychiatric information that is protected under state and federal law [Connecticut General Statutes, Title 52, Chapter 899, §§52-146c through 52-146i, inclusive; and the U.S. Health Insurance Portability and Accountability Act of 1996]. Accordingly, please note that:

> "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 general authorization for the release of medical or other information is NOT sufficient for this purpose."

Drug and Alcohol Treatment information: 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 treatment for drug and/or alcohol abuse that would be in violation of federal or state law. In the event that the records disclosed or requested contain information regarding treatment for drug and/or alcohol abuse, please note the following:

> "The confidentiality of this record is required under state law [Connecticut General Statutes, Title 17a, Chapter 319j, §17a-688] and federal confidentiality rules and regulations [42 CFR part 2 and the U.S. Health Insurance Portability and Accountability Act of 1996]. These laws, rules and regulations prohibit you from making any further disclosure of these records unless further disclosure is expressly permitted by the written consent of the person to whom the records pertain or as otherwise permitted by state law and federal rules and regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules and regulations further restrict the use of information regarding alcohol and/or drug abuse treatment to criminally investigate or prosecute any alcohol or drug abuse patient."

Rules Regarding the Consent of Minors: Under Connecticut law, minors have various rights with respect to the release of information under certain circumstances:

- "Emancipated" minors (i.e., children under age 18 who have obtained a court declaration of emancipation - legal emancipation) have full control over the disclosure of their medical and other private records.
- "Mature" minors (e.g., minors who are married, serving in the armed forces, evicted from the parental home, or otherwise living as if adult in status) may have full control over access to their medical and other private records.
- Under Connecticut law, 16- and 17-year olds are considered to be adults with respect to inpatient mental health treatment and have full control over the disclosure of their inpatient psychiatric records.
- Minors of any age who are capable of giving informed consent and are receiving outpatient mental health treatment (including PHP, IOP and EDT) have full control over the disclosure of their outpatient treatment records (there may be special exceptions with respect to pharmaceutical treatment – consult with HIM or A/CM for details).
- Minors of any age who are capable of giving informed consent and are in treatment for substance abuse have full control over the disclosure of their substance abuse treatment records, including any disclosure of their involvement in treatment (there are special exceptions – consult with HIM or A/CM for details).
- Information about consultation, examination or treatment of a minor for HIV/AIDS cannot be disclosed without the minor's consent.
- Information about consultation, examination or treatment of a minor for venereal diseases cannot be disclosed without the minor's consent.
- Medical records of a female receiving an abortion cannot be disclosed without her consent.
- School records for children under age 18 cannot be disclosed without the consent of the child's parent(s)/legal guardian(s).

Natchaug Hospital
189 Storrs Road
Mansfield Center, CT 06250
Phone: (860) 456-1311
Fax: (860) 423-1381

Sachem House
189 Storrs Road
Mansfield Center, CT 06250
Phone: (860) 465-5944
Fax: (860) 423-5922

RiverEast Day Hospital & Treatment Center
428 Hartford Turnpike
Vernon, CT 06066
Phone: (860) 870-0119
Fax: (860) 870-0122

Quinebaug Day Treatment Center
11 Dog Hill Road
Dayville, CT 06241
Phone: (860) 779-0321
Fax: (860) 779-0363

Joshua Center –Young Adult - Mansfield
189 Storrs Road
Mansfield Center, CT 06250
Phone: (860) 465-5957
Fax: (860) 423-5922

Joshua Center – Shoreline
5 Research Parkway
Old Saybrook, CT 06475
Phone: (860) 510-0163
Fax: (860) 510-0486

Joshua Center – Danielson
934 North Main Street
Danielson, CT 06239
Phone: (860) 779-2101
Fax: (860) 779-3807

Joshua Center – Enfield
72 Shaker Road Suite 7
Enfield, CT 06082
Phone: (860) 749-2243
Fax: (860) 749-2613

Joshua Center Thames Valley
11A Stott Avenue
Norwich, CT 06360
Phone: (860) 823-5320
Fax: (860) 886-6567

Care Plus & Joshua Center
1353 Gold Star Highway
Groton, CT 06340
Phone: (860) 449-9947
Fax: (860) 445-0414

Journey House
189 Storrs Road
Mansfield, CT 06250
Phone: (860) 696-9871
Fax: (860) 423-1109

Green Valley Scool
206 Pond Rd.
North Franklin, CT 06254
Phone: (860) 809-0410
Fax: (860) 642-0705

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