THE WILLIAM W. BACKUS HOSPITAL

326 WASHINGTON STREET NORWICH CT 06360

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION RELATED TO SUBSTANCE ABUSE, IMMUNODEFICIENCY VIRUS (HIV), AND/OR MENTAL HEALTH RECORDS

Patient Name: ____ Social Security #_____________________________

Date of Birth _______________ Date of Admission or specific Treatment Date(s)_____________________________________

AKA (Other names) ____

I hereby authorize The William W. Backus Hospital to disclose my individually identifiable health information to _____________________

____

(Name & address of individual, organization or agency and address)

in the manner described below.

I hereby authorize ____

(Name and address of individual, organization or agency and address)

to disclose identifiable information in the manner described below to The William W. Backus Hospital.

1. Information should be delivered via (select one)		Mail (provide address):		
		Fax (provide fax number):		
		Pick-up (provide name of individual picking up information):		
		Verbal		
2. Purpose of this disclosure (check all that apply)		Continuation of medical care		Attorney
		Substantiation of payment claims		Personal use
		Other (specify):		
3. Information to be disclosed (include dates where appropriate)		Substance Abuse Records		
		HIV Test Results		
		Mental Health Records (not to include psychotherapy notes)		
4. If you are the legally authorized representative of the patient, describe the scope of your authority to act on the patient's behalf		Parent		
		Durable Power of Attorney for Health Care (attach proof of authority)		
		Legally Authorized Representative (attach proof of authority)		
		Personal Representative of the Estate (attach proof of authority)		
		Other (specify and attach proof of authority)		

5. **I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above could be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.**

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Record Department of the entity authorized to release this information. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company as the law provides my insurer with the right to contest a claim under my policy.

7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.

8. I understand that this will expire ____.

   (insert applicable date or event)

Signature of Patient or Legally Authorized Representative ________________________________ Date ____________________

Relationship to Patient ___________________________________ Witness ____

ID Checked by ____________________Request # __________

THE WILLIAM W. BACKUS HOSPITAL
326 Washington Street Norwich CT 06360
(860) 889-8331

SPECIAL NOTICES REGARDING CONFIDENTIAL INFORMATION

Mental Health Records

In the event that information released constitutes privileged psychiatrist/clinician-patient communications:

> The confidentiality of this record is required under Chapter 889 of the Connecticut General Statutes. This material shall not be transmitted to anyone without written authorization as provided in the aforementioned statutes.

Drug and Alcohol Abuse Records

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 Regulations (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/AIDS – Related Information

In the event that information released constitutes confidential HIV/AIDS – related information protected under Connecticut law:

> This information has been disclosed to you from records whose confidentiality is required by law and no information from such records may be transmitted to anyone else without written consent or authorization as provided for under Connecticut General Statutes, Chapters 899 and 368X and Federal Regulations 42 CFR 2. 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.