

AUTHORIZATION & FAX TRANSMITTAL TO RELEASE PERSONAL HEALTH INFORMATION
University of Connecticut Student Health Services (SHS) Counseling & Mental Health Services (CMHS)

[] SHS 860-486-4700 SHS Medical Records FAX 860-486-5300

234 Glenbrook Road, U-4011 Storrs, CT 06269

[] CMHS 860-486-4705 CMHS FAX 860-486-9159

337 Mansfield Road, U-1255 Storrs, CT 06269

Patient's Name (Please Print)		
Name If different at time of visit(s) or treatment(s):		
Date of Birth	ID# or S.S.#	Telephone #
<input type="checkbox"/> Release Information To: I authorize that my UConn SHS/CMHS information be disclosed to and used by the individual below.		<input type="checkbox"/> Obtain Information From: I authorize information from another healthcare provider/ agency/hospital/clinic, listed below, be provided to UConn SHS/CMHS.
Name		Name
FAX #	Phone#	FAX # Phone#
Address		Address
City		City
State	Zip	State Zip
Method of Disclosure: <input type="checkbox"/> Mail <input type="checkbox"/> FAX <input type="checkbox"/> Verbal <input type="checkbox"/> Review <input type="checkbox"/> Pickup on this date:		UCONN SHS/CMHS Clinician who needs information:
Comments:		

The purpose of this request is for:

- Dr./Clinician visit Insurance claim Legal matter Meal Plan Exemption
 Clinical site visit for Allied Health, Nursing, PT & Pharmacy Other specify): _____

Information to be released please check:

Date(s) of visit(s) or treatment (s):			
<input type="checkbox"/> Copy of entire Primary Care record (will include Women's Clinic, drug & alcohol, communicable disease information including HIV test results, notes and related information, if any). Does not include Mental Health records unless indicated below.			
<input type="checkbox"/> Copy of Mental Health record (will include drug & alcohol, HIV related information, if any)			
<input type="checkbox"/> Lab	<input type="checkbox"/> X-ray	<input type="checkbox"/> Women's Clinic	<input type="checkbox"/> Encounter Notes
<input type="checkbox"/> HIV Information	<input type="checkbox"/> Drug and Alcohol Records	<input type="checkbox"/> Alcohol & Other Drugs Program	
<input type="checkbox"/> Information for clinical program sites		<input type="checkbox"/> Other (Specify)	

AUTHORIZATION

I the undersigned, hereby authorize the release of the above personal health information as I have indicated. I understand that there may be a charge of \$0.65 per page depending on the purpose of this request. I understand that I may revoke this authorization to release information at any time by giving written notice. However, I understand that any information released prior to my revoking this authorization shall not be a breach of my right to confidentiality. Unless I revoke this authorization prior to such time, this authorization shall expire _____ (90 days if left blank.)

MENTAL HEALTH/SUBSTANCE ABUSE/HIV/AIDS: I understand that information to be released or obtained may include mental health information in accordance with CGS 52-146(d), substances abuse treatment information in accordance with 42 CFR 2.1-2.67, and HIV/AIDS-related information in accordance with CGS 19a-585(a), except as indicated below.

PROHIBITION ON REDISCLOSURE: This information has been disclosed from records whose confidentiality is protected by Federal and State law. Regulations prohibit making any further disclosure of this information except without the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose. Regulations state that any person who violates any provision of this law shall be fined not more than \$500 in the case of the first offense and not more than \$5,000 in the case of each subsequent offense.

I consent to the redisclosure of information with these conditions: (PLEASE CHECK ONE)

- Include all records from outside agency/providers except _____
 Do not include any records from outside agency/provider.

 Patient's Signature/Personal Representative Date

If personal representative please note relationship to the patient: Parent Guardian Spouse Domestic Partner Other _____

PLEASE NOTE: If faxed, the information contained in this facsimile message is privileged and confidential and intended for the use of the addressee listed above. If you are neither the intended recipient or the employee or agent responsible for delivering this information to the intended recipient, you are hereby notified that any disclosure, copying, distribution, or taking any action in reliance on the content of this telecopied information is strictly prohibited. If you have received this copy in error, please immediately notify the sender to arrange for return of the original documents to us.