ELLINGTON BEHAVIORAL HEALTH
16 Main Street
Ellington, CT 06029
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AUTHORIZATION FOR DISCLOSURE/OBTAINING HEALTH INFORMATION

Subject to the statements printed on this page, I, the undersigned patient or legal representative, hereby authorize the use and disclosure of health information including, if applicable, information relating to the diagnosis or treatment of mental illness, drug and/or alcohol abuse and HIV related information.

Patient Name: Date of Birth:

I authorize Ellington Behavioral Health to:

☐ **DISCLOSE** protected health information from my medical record, relating to Behavioral and Mental Health Records, 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, relating to Behavioral and Mental Health Records, either orally or in written form, **from** the individual(s), agency or organization specified below.

_____
Name of Party/Organization/Relationship

_____
Address (Street, City, State)

_____
Telephone Fax

The dates of service to be used or disclosed are as follows: (If left blank Ellington Behavioral Health will only send/request 1 year back from the date of this release worth or records)

☐ DATE(S) OF TREATMENT: _____
☐ ALL PRIOR EPISODES OF CARE AND ONGOING COMMUNICATION/TREATMENT

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)
☐ HIV/AIDS testing, diagnosis, status and/or treatment
☐ Other (specify): _____

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

☐ Medical ☐ Legal ☐ Disability ☐ Insurance ☐ Other:_____

I understand that Ellington Behavioral Health does not copy records that are not originals or records that are sent to our office by other providers of care. I also understand that information disclosed to any person(s), agency or organization, other than a healthcare provider or other entity covered by applicable state and/or federal privacy regulations, may be re-disclosed by that person(s), agency or organization without my consent and without my being informed of the disclosure.

YOUR RIGHTS:

I understand I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies by calling Ellington Behavioral Health. I further understand that there may e a fee for copying my medical information and that copying of this information will be performed within a reasonable time frame, but not on demand. I understand that if I agree to sign this authorization, which I am not required to do, I have the right to receive a copy of this form and that the person(s), agency or organization listed above who I am authorization to use and/or disclose my information may not condition treatment on my decision to sign this authorization. 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 Ellington Behavioral Health. I acknowledge that any such revocation cannot and will not apply to any information released or obtained by Ellington Behavioral Health through actions taken prior to the date at which a written request for revocation is presented.

Signing this form does not mean you are necessarily stating that you have a substance use disorder or HIV; rather that you understand your record is protected by Federal statute whether you do or not.

Initial: _____ I specifically authorize the release of personal health information relating to drug and/or alcohol abuse. I understand that my records are protected under Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2) and cannot be disclosed without my written consent unless otherwise provided for in the federal regulations. The recipient of drug and/or alcohol abuse information disclosed as a result of this authorization will need my further written authorization to re-disclose this information.

Initial: _____ I specifically authorize the release of information relating to Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Syndrome (HIV).

I have had an opportunity to review and understand the content of this authorization form. By signing this form, I am authorizing Ellington Behavioral Health to send and/or receive protected health information and that it accurately reflects my wishes.

SIGNATURE OF CLIENT/PARENT/LEGAL REPRESENTATIVE DATE

If the client is under 18 or has a legal guardian, please print name below and relationship to client.

PRINT NAME AND RELATIONSHIP TO CLIENT DATE

ELLINGTON BEHAVIORAL HEALTH STAFF DATE