



# WATERBURY HOSPITAL

64 Robbins Street  
Waterbury, CT 06708

## Authorization to Disclose Health Information

1. I hereby authorize **The Waterbury Hospital** to disclose my individually identifiable health information as described here to the person/organization named below. I understand that this authorization is voluntary and that it **may include information relating to AIDS, HIV infection, behavioral health services / psychiatric care, treatment for alcohol and/or drug abuse.**

|                |       |                        |
|----------------|-------|------------------------|
| PATIENT'S NAME |       | DATE OF BIRTH          |
| ADDRESS        |       | SOCIAL SECURITY NUMBER |
| CITY           | STATE | PHONE NUMBER           |

Dates of Service \_\_\_\_\_

2. Information to be disclosed / obtained:

- |  |   |
|--|---|
| <input type="checkbox"/> Discharge Summary   | <input type="checkbox"/> Radiology films/CD     |
| <input type="checkbox"/> History & physical examination  | <input type="checkbox"/> Radiology reports      |
| <input type="checkbox"/> Consultation reports  | <input type="checkbox"/> Psych/Drug/Alcohol/HIV |
| <input type="checkbox"/> Emergency Room record   | <input type="checkbox"/> Laboratory tests       |
| <input type="checkbox"/> Entire record (Consideration will be given to releasing the entire record ONLY when subsections of the record will not serve the intended purpose of the disclosure.) |   |
| <input type="checkbox"/> Other (please specify): _____   |   |
| <input type="checkbox"/> Bills   |   |

3. I understand that information to be released or obtained may include mental health information in accordance with CGS 52-146(d), substance abuse treatment information in accordance with 42 CFR 2.12.67, and/or HIV/AIDS-related information in accordance with CGS 19a-586(a), except as indicated below.

- No Mental Health       No Substance Abuse treatment information       No HIV/AIDS

4. Name of person(s) / organization(s) to whom the disclosure is to be made:

|         |       |                  |
|---------|-------|------------------|
| NAME    |       | TELEPHONE NUMBER |
| ADDRESS |       |                  |
| CITY    | STATE | ZIP              |

5. Name and relationship to patient of the individual authorized to pick up the record(s) being released from the facility:

\_\_\_\_\_

6. I am requesting that this information be disclosed for the purpose of (*i.e.*, *Legal reasons, continued care, insurance, another medical opinion, Worker's compensation, research, personal use, Social Security*):

\_\_\_\_\_  
\_\_\_\_\_

7. I understand this authorization may be revoked **in writing** at any time, except to the extent that action has already been taken in reliance on this authorization. This authorization shall automatically expire 6 months from the date of signature unless otherwise specified in the space provided here. **DATE OF EXPIRATION:** \_\_\_\_\_

2-Hole 1/4 2 3/4 - 3-Hole 1/4 4 1/4

- 8. I understand that I may inspect and copy the information to be used and disclosed under this authorization and that I may receive a copy of this signed authorization form. There may be a fee associated with copying, not to exceed what is authorized by Connecticut State law.
- 9. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
- 10. I understand that Waterbury Hospital may not condition treatment on the provision of this authorization except in cases of research-related treatment protocols or studies being conducted by outside third parties through Waterbury Hospital. In such cases, specific authorization for the research-related treatment protocols / studies must be signed as a condition of participation.

**Notice to Recipients:**

*As the recipient of this information, you may use this information only for the stated purpose. You may disclose this information to another party ONLY:*

- *With written authorization from the patient or his or her legal representative;*
- *As required or authorized by state and / or federal law; or*
- *If urgently needed for the patient's continued care.*

**If this disclosure contains information relating to HIV, behavioral health, alcohol or drug abuse education, training, treatment, rehabilitation, or research, the following shall apply:**

**This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (Title 42 CFR Part 2 and Ch. 368x) prohibit 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 such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.**

**Notice to Individual Requesting the Disclosure:**

*Your signature below indicates that you understand that if the organization authorized to receive the information is not a health care provider or health plan, and the information disclosed is NOT protected by the Title 42 CFR Part 2 and Ch. 368x, then the released information may no longer be protected by the HIPAA Federal Privacy Regulations.*

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of Legal Representative

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Signature of Individual Picking up Record

\_\_\_\_\_  
Relationship to patient

**For Office Use Only**

|                         |  |
|-------------------------|--|
| Sign & Date             |  |
| Check Identification    |  |
| Date records needed by: |  |
| Charges:                |  |

**NOTES:** \*\* (When using this form in the Laboratory, a physician signature is required to disclose results to anyone.)

\_\_\_\_\_  
Physician Signature and Date