Yale HEALTH

Mental Health and Counseling
550 Lock Street
PO Box 208237
New Haven, CT 06520-8237
Phone: 203-432-0290
Fax: 203-432-8458

Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____ Date of Birth: _____

Address: _____ Daytime Phone: _____

_____ Evening Phone: _____

I authorize Yale Health Mental Health and Counseling department to use or disclose information from my mental health record, which may include information about psychiatric diagnosis, treatment, and substance abuse issues to:

Name: _____

Address: _____ Phone: _____

_____ Fax: _____

Information to be released for time period of _____

- ❑ History and physical exam
- ❑ Immunizations
- ❑ Lab report
- ❑ X-ray report
- ❑ Consultation report/notes
- ❑ Prescription Information
- ❑ Notes and test results related to: _____
- ❑ Other/Comments: _____

I understand that this health information may include sensitive information. By signing this form I am specifically authorize the release of information relating to:

- ❑ Substance Abuse Treatment information
- ❑ HIV related information, including AIDS related testing
- ❑ Mental Health Information

Signature _____

Date: _____

The confidentiality of this record is required under Chapter 899 of the Connecticut General Statutes as well as Title 42 of the United States code. This material shall not be transmitted to anyone without written consent or authorization as provided in these statutes.

Preferred Format: ☐ CD ☐ Paper

Purpose of Disclosure: ☐Treatment ☐Workers Compensation ☐Legal ☐School

☐Other: _____

1. I understand that this authorization will expire 180 days from my last date of service visit. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying the Mental Health and Counseling department, in writing, and this authorization will cease to be effective on the date notified except tot he extent actionhas already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
4. My health care and payment for my health care will not be affected if I do not sign this form.
5. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
6. I understand that I will get a copy of this form after I sign it.

By signing below, I acknowledge that I have read and understand this Authorization.

_____ OR _____ _____

Signature of Patient **Parent/Legal Guardian/Authorized Person** Date

_____

Relationship to Patient

Revision date: 12/2016