

Authorization for Use or Disclosure of Protected Health Information

Patient Name: Date of Birth:
Address: Daytime Phone:
Evening Phone:

I hereby authorize Yale University to (choose one):

- use or disclosure my protected health information as indicated below TO:
obtain my protected health information FROM:

Name:
Address: Phone:
Fax:

Information to be released for time period of to :

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

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

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.

Signature

Date:

Preferred Format: CD Paper

Purpose of Disclosure: Treatment Workers Compensation Legal School

Other:

- I understand that this authorization will expire two years from my last date of service visit. A photocopy of this form will be considered as valid as the original.
I understand that I may revoke this authorization at any time by notifying the Privacy Officer, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it. Send revocation to: HIPAA Privacy Officer, Yale University, PO Box 208252, New Haven, CT 06520-8252
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.
My health care and payment for my health care will not be affected if I do not sign this form.
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.
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

For records requested to be sent to Yale, please send records to: Yale Health, P.O. Box 208237, New Haven, CT 06520-8237 or fax to 203-436-5536 or email to yhmedicalrecords@yale.edu.