Yale HEALTH
Mental Health & Counseling
PO Box 208237
New Haven, CT 06520-8237
Phone: 203-432-0290 Fax: 203-432-8458

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH RECORD

(Also known as Protected Health Information)

PATIENT NAME _____ Date of Birth _____

Address (Mailing) _____ Phone _____

_____

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

Name:_____ Phone _____

Address:_____ FAX _____

_____

Dates of Treatment: _____

Information to be released (Please describe) _____

Purpose of Disclosure _____

1. I understand that, unless withdrawn, this authorization will expire 180 days from the date of signature. 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 Department of Mental Health & Counseling at the address indicated above, 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.
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 and mental health information.
4. 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.
5. My health care and payment for my health care at Yale Health Center will not be affected if I do not sign this form.
6. I understand that I can request a copy of this form after I sign it.
7. I understand that in compliance with CT general statute, I will pay a fee of $0.65 per page.

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

_____ _____ OR _____ _____

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

_____

Relationship to Patient