

Client First, Last Name: _____

Client Date of Birth: _____

INSTRUCTIONS: AUTHORIZATION TO REQUEST OR RELEASE PROTECTED HEALTH INFORMATION

The Authorization to Request or Release Protected Health Information form has a dual purpose. It can be used when requesting records be released **from** Child & Family Agency of Southeastern Connecticut, Inc (CFA) or when requesting that records be sent **to** Child & Family Agency of Southeastern Connecticut, Inc from an outside entity. The form is generally used when the client or parent/legal guardian is required to authorize the release or disclosure of protected health information.

**Please note that record requests may be subject to a copying fee.*

Section 1. Please provide client identifying information, including full legal name, date of birth, street address, and contact information.

Section 2. In the FROM box, name the organization or provider that is providing records (typically, Child & Family Agency of Southeastern Connecticut, Inc).

In the TO box, name the organization or provider to whom you would like the records released (for example: “self” or “Doctor’s Office” or “Attorney’s Name” or “Insurance Company Name”).

Section 3. Indicate the type of records you would like released. Clients between 13-17 years of age must consent for the release/request of sensitive health information. If you are a Parent/Legal Guardian and any of those boxes are checked, a CFA staff member will be reaching out to your adolescent for their consent and giving them a copy of this form.

Section 4. Identify the purpose or reason for the request. Also enter the manner in which you would like the records released.

Section 5. Outlines important information pertaining to this authorization.

Section 6. In order for this information to be released, please sign and date the form. Information cannot be released without appropriate authorized signature.

Forms that are incomplete, or can not be read due to unclear handwriting are considered invalid and will be returned for completion.

If you have any questions, please contact CFA’s Quality Team at (860)437-4550 ext. 923.
Thank you!

AUTHORIZATION TO REQUEST OR RELEASE PROTECTED HEALTH INFORMATION (PHI)

SECTION 1: CLIENT INFORMATION

Legal First Name: _____ Legal Last Name: _____

Date of Birth: _____ Phone Number: _____

Client Address: _____ City: _____ State: _____ ZIP: _____

SECTION 2: AUTHORIZATION DETAILS

FROM: (select one) ☐ Child & Family Agency of Southeastern Connecticut, Inc Phone: (860)437-4550 Fax: (860)661-4262 ☐ Other Organization/Provider (Specify below): Name: _____ Address: _____ Phone Number: _____ Fax Number: _____	TO (Note "self" if sending to client): (select one) ☐ Other Organization/Provider (Specify below): Name: _____ Address: _____ Phone Number: _____ Fax Number: _____ ☐ Child & Family Agency of Southeastern Connecticut, Inc Phone: (860)437-4550 Fax: (860)661-4262
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SECTION 3: INFORMATION REQUESTED OR RELEASED (Select all that apply)

Protected Health Information Medical Health Record ☐ Last History & Physical Exam ☐ Lab Results ☐ Immunization Record ☐ Medication List ☐ After Visit Summary Behavioral Health Record ☐ Intake Evaluation ☐ Treatment Plan Updates ☐ Progress Notes ☐ Discharge Summary ☐ Other: _____	*Specifically Protected Health Information ☐ *Substance Abuse (which includes Alcohol and Drug Abuse) ☐ *Reproductive Health ☐ *Sexually Transmitted Disease ☐ *HIV/AIDS Status <i>*Clients between 13-17 years of age must consent for the release/request of sensitive health information. If you are a parent/guardian and any of the three top boxes are checked, a CFA representative will be reaching out to your adolescent for their consent and giving them a copy of this form.</i>
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SECTION 4: AUTHORIZATION PURPOSE & DELIVERY METHOD

PURPOSE (Choose one): ☐ Medical Care ☐ Behavioral Health Care ☐ Personal ☐ Insurance ☐ Legal Matter ☐ Other (specify): _____	METHOD OF DELIVERY (Choose one): ☐ Email ☐ Fax ☐ Paper Copy for Office Pickup or Certified Mail (fees may apply)
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SECTION 5: OTHER IMPORTANT INFORMATION

- This authorization will expire within one year from the date of the last collected signature date unless revoked. Clients and Parents/Legal Guardians may revoke this authorization at any time by contacting CFA in writing.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of your information and is no longer protected by the HIPAA Privacy Rule. Pursuant to 45 CFR § 164.508, the information disclosed pursuant to this authorization is not subject to re-disclosure by the recipient without a separate authorization for that purpose except as provided by said statute.
- The parent or legal guardian must sign this authorization if the patient is a minor (under age 18) unless the records relate to treatment(s) for which the minor may provide consent under CT state law. If HIV, Drug/Alcohol information is included, the minor must sign as consented below.
- Medical records containing protected information under applicable federal or state laws must also be authorized by a minor when age 13 or older (e.g. HIV, substance abuse including alcohol and drug abuse, reproductive health, and/or sexually transmitted disease).
- Fees may apply per Connecticut state law and CFA policy.
- Questions regarding records requests can be addressed by the CFA Quality Team Call by phone call to (860)437-4550 ext. 923

SECTION 6: CONSENT FOR RELEASE/REQUEST OF PHI & SIGNATURES

Person Requesting or Authorizing the Release of PHI (Select only one)

- ☐ I am 13 years of age or older and consent to my protected health information being requested/released as outlined above. I understand my consent is required for sensitive information to be shared and have reviewed the request from my parent/legal guardian.
- ☐ I am 18 years of age or older and consent to my protected health information being requested/released as outlined above.
- ☐ I am the parent/legal guardian of a minor receiving services at Child and Family Agency and consent to the client's protected health information being requested/released as outlined above. My information is below:

Printed First Name _____ Printed Last Name _____

Phone Number _____

Relationship to Client (select one): **Parent/Legal Guardian** **Other(specify):** _____

Street Address: _____ City: _____ State: _____ ZIP: _____

SIGNATURE(S)

Client/Person to Receive Services Signature (if 13 years of age or older)

Date (MM/DD/YYYY) _____

Printed Name (First & Last) _____

Signature _____

Parent/Legal Guardian Signature (if applicable)

Date (MM/DD/YYYY) _____

Printed Name (First & Last) _____

Signature _____