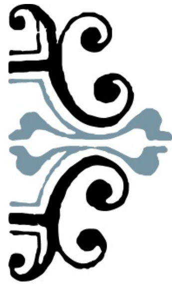

Amy Lane, APRN

Primary Mental Health & Family Nurse Practitioner

410 Salem Turnpike, Bozrah, CT 06334

Phone: 860-823-0245 Fax: 860-213-8350

AUTHORIZATION T0 OBTAIN & RELEASE CONFIDENTIAL INFORMATION

Patient's Name: ______________________ Date of Birth: ______________

Previous Name: ______________________ Social Security # (optional): ______________

I request and authorize ________________________________ to

release healthcare information of the patient named above to:

Name: ________________________________

Address: ________________________________

City: ______________ State: ______ Zip Code: __________

Phone: Fax:

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: ______________

____

☐ Psychiatric Evaluation ☐ Discharge Summary and/or ☐ Psychological Testing

☐ Other: ________________________________

I understand that my records are protected under State and Federal Confidentiality regulations (Sec.42 USC 290dd-3 and 42 USC 290ee-3 for federal laws and 42 CFR Part 3 for federal regulations) and cannot be disclosed without my written consent. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and in a (e.g., probation, parole, etc) and in any event this consent expires automatically as described below. I also understand that the information released by the consent shall not be further relayed in any way to any other person, entity, or others without additional written consent from me. The record to be released may contain information pertaining to psychiatric, drug, and or alcohol diagnoses and treatment, and may also contain confidential HIV (AIDS) related information.
I understand that my mental health and or alcohol and or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R Part 2, and the Health Insurance Portability Act of 1996 (HIPPA), 45 C.F.R. Pts. 160 &164 and cannot be disclosed without my written consent unless otherwise provided for in these regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

This information will be released for the following purpose (any other use is prohibited):

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: ______________________ Date Signed: ______________

Signature of Guardian: (if applicable) ______________________ Date Signed: ______________

Signature of Witness: ______________________ Date Signed: ______________