• W C B H •

Western Connecticut Behavioral Health, LLC

Consent to Release Confidential Information to Another (third) Party

PATIENT NAME: ___________________________ DATE OF BIRTH: _____________

1. I, ____ (Patient/Parent Name), am completing this form to allow the use and sharing of my protected health information.

2. I authorize Western CT Behavioral Health to ☐ exchange or ☐ disclose or ☐ obtain the information noted below to this person &/or organization:

   (List below the person(s) and/or the organization(s) that will be receiving your records from Western Connecticut Behavioral Health; please, be sure to provide complete address and contact information for this “third” party)

   ____

   Street: ______________________ City: ______________ Zip Code: __________

   Phone: ______________________ Fax (if known): ______________________

3. The information that may be disclosed, obtained, and/or exchanged through this authorization:

   ☐ Verbal interactions
   _____ Mental Health
   _____ Substance Abuse
   _____ HIV / AIDS Status
   ☐ Medical Records
   ☐ Investigation Protocol
   ☐ Legal Records and Work Product
   ☐ Court Records
   ☐ Intake and/or Discharge Summary
   ☐ All assessments conducted, including the psychological, neuropsychological, court or school evaluations
   ☐ Copies of relevant school records including evaluations and Individual Education Plans
   ☐ Copy of final psychological testing report written by evaluator
   ☐ Other specific information ____

4. The information will be used for the following purposes (e.g. continuity of care, custody hearing, etc.):
   ____

5. I understand and agree that this Authorization will be valid for one year from this date unless specified otherwise here: ____
   I understand that after that date or event, no more of this information can be used or released to the person or organization unless I sign a new Authorization like this one.

_______________________________________ ______________________

Signature of Client or His/her Personal Representative Date

828 Federal Road, Brookfield, CT 06804 ▪ phone (203) 885-0500 ▪ fax (203) 702-5345

I understand that after that date or event, no more of this information can be used or released to the person or organization unless I sign a new Authorization like this one.

6. I understand that I can revoke or cancel this authorization at any time by sending a letter to Western Connecticut Behavioral Health. If I do this, it will prevent any disclosures after the date it is received but cannot change the fact that some information may have been sent or shared before that date.

7. I understand that I may inspect and have a copy of the health information described in this authorization. There may be a cost for this copy or other services.

8. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

9. I understand and agree that there may be administrative charges associated with the use or disclosure of my health information. The relevant financial arrangement has been explained to me and I understand and accept it.

10. I affirm that everything in this form that was not clear to me has been explained and I believe I now understand all of it.

The Confidentiality of this record is required under Chapter 899 of the Connecticut General Statutes; Title 42, Part 2 of the United States Code of Federal Regulations., and the Health Insurance Portability and Accountability Act (HIPPA) where applicable. This material is not to be transmitted to anyone without the client's/patient's written consent or authorization as provided for in these statutes. Once received by the intended party, this information is not for re-disclosure.