Visiting Nurse and Health Services of Connecticut (VNHSC)
8 Keynote Drive
Vernon, CT 06066

AUTHORIZATION TO RELEASE OR OBTAIN HEALTH INFORMATION

No part of this authorization is a required field. However, it is requested to assist ECHN in fulfilling your request accurately. There may be a reasonable, cost-based fee that complies with both federal and state regulations, associated with this request.

1. Patient Information

NAME *(Last, First, Middle Initial)*		**MAIDEN/OTHER NAME**
DATE OF BIRTH	**PREFERRED PHONE NUMBER** ( )	**ARE YOU A VETERAN?** ☐ YES ☐ NO

2. Release To/Obtain From

I HEREBY AUTHORIZE ECHN TO: ☐ Release Information **TO** ☐ Obtain Information **FROM**

NAME OF PERSON OR INSTITUTION	**PHONE NUMBER** ( )	**FAX NUMBER** *(Healthcare Providers Only)* ( )

MAILING ADDRESS *(Number/Street/Apartment No./PO Box)* *(City/Town)* *(State)* *(Zip Code)*

FORM/FORMAT
I request that the information be provided in the form/format outlined below where possible/available:
☐ Paper ☐ Electronically on CD/disc/flash drive ☐ Other *(Please Specify)*: _____

METHOD OF DELIVERY
☐ Mail ☐ Verbal ☐ Pick-Up Onsite *(Photo-ID Required)* ☐ Fax *(Healthcare Providers Only)*
☐ By Unencrypted E-mail to This Email Address******: _____ *(Initial)* _____
****** *I am requesting my protected health information be delivered in an unencrypted format. I understand and accept all risks associated with releasing my medical record information using unencrypted electronic formats, including access by an unintended third party.*

3. Information Request

DATE(S) OF SERVICE FROM: _____ **to** _____

TYPE OF INFORMATION TO BE RELEASED OR OBTAINED *(Check One or More)*

☐ Discharge Summary	☐ PT/OT/Speech Note(s)	☐ Physician Orders
☐ Nursing Notes	☐ Billing Claims	☐ Discharge Summary
☐ In-Home Mental Health Nursing Notes	☐ Outcome and Assessment (OASIS)	

Other Information *(Please Specify)***:** _____

If any of the above information being requested contains the following sensitive information, please initial.
AIDS/HIV Information: _____ *(Initial)* **Drug/Alcohol Information:** _____ *(Initial)* **Mental Health Information:** _____ *(Initial)*

PURPOSE *(Optional, Access Will Not Be Denied Based On Providing This Information)*
☐ Patient or Legal Representative ☐ Other Healthcare Providers ☐ Supporting a Claim/Appeal ☐ Legal
☐ Other *(Please Specify)*: _____

4. Authorization

AUTHORIZATION EXPIRES *(If no expiration given, authorization will expire twelve (12) months from the signature date)*
☐ ONE (1) Year From Date of Authorization **OR** ☐ Other Date *(Please Specify)*: _____/_____/_____

I hereby authorize Eastern Connecticut Health Network or its wholly owned affiliates (collectively "ECHN") to release, disclose or obtain the records described above for such purposes described above. I understand the following:

- *I have the right to cancel (revoke) this authorization in writing to the respective Health Information Management Department or Privacy Officer, at any time. My right to revoke this authorization can be found in ECHN's Notice of Privacy Practices. Cancellation of the authorization will not apply to information that has already been released or disclosed based upon this authorization.*
- *This authorization is voluntary; my treatment at ECHN is in no way conditioned on whether or not I sign this authorization.*
- *If the recipient of the information is not a healthcare provider or health plan covered by the federal Privacy Rule, the information used or disclosed as described above is no longer protected by the Privacy Rule and may be re-disclosed by the recipient.*

Patient Signature ***(Please let a Health Information Management Associate know if assistance is needed, or if unable to sign form)***

Patient Print Name X	**Patient Signature** X	**Date/Time**

Requestor Other Than Patient

If the patient has not signed this form, please indicate the relationship of the requestor to the patient:
***** *You **MUST** attach proof of your authority to act on behalf of the patient as checked below (other than parent).*
☐ Parent ☐ Legal Guardian ☐ Healthcare Representative ☐ Conservator ☐ Executor/trix of Estate ☐ Power of Attorney
☐ Other *(Please Specify)*: _____

Requestor Print Name X	**Requestor Signature** X	**Date/Time**

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PROHIBITIONS ON REDISCLOSURE NOTICE

AIDS OR HIV RELATED INFORMATION

In the event that information released constitutes confidential AIDS/HIV related information protected under Connecticut Law:

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

DRUG AND ALCOHOL ABUSE TREATMENT INFORMATION

In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records Regulations:

This information has been disclosed to you from records protected by federal and state confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31, 42 CFR Part 2). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65.

MENTAL HEALTH TREATMENT INFORMATION

In the event that the information released constitutes privileged psychiatrist-patient communications:

The confidentiality of this record is required under Chapter 899 of the Connecticut General Statutes. This material shall not be transmitted to anyone without written consent or other authorization as provided in the aforementioned statutes.

STATEMENT OF NONDISCRIMINATION AND AVAILABILITY OF COMMUNICATION SERVICES

English: ECHN complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATTENTION: If you speak English or any other language, language assistance services are available to you free of charge. Call 1-860-646-1222.

Español (Spanish): ECHN cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-860-646-1222.

Polski (Polish): ECHN postępuje zgodnie z obowiązującymi federalnymi prawami obywatelskimi i nie dopuszcza się dyskryminacji ze względu na rasę, kolor skóry, pochodzenie, wiek, niepełnosprawność bądź płeć. UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-860-646-1222.

Copy to Medical Record
Copy to Patient/Representative