

DAY HILL PSYCHOTHERAPY
110 Day Hill Road, Windsor, CT 06095
AUTHORIZATION TO DISCLOSE / OBTAIN PROTECTED HEALTH INFORMATION
ALL LISTED INFORMATION IS REQUIRED AND MUST BE FILLED IN

Subject to the statements printed below, I, the undersigned patient or legal representative, hereby authorize the use and disclosure of health information including, if applicable, information relating to the diagnosis or treatment of mental illness, drug and/or alcohol abuse and HIV related information.

Name _____ Date of Birth _____

Fill out this section for	J. Gialopsos, LCSW	T. Bodine, LCSW	T. Reif, PhD,	Jenabeth Rush, LPC
I authorize the provider circled above to disclose mental health information to				
Name: _____	Facility: _____			
Address: _____				
Telephone: _____	Fax: _____	Method: <input type="checkbox"/> Mail <input type="checkbox"/> Verbal <input type="checkbox"/> E-Mail <input type="checkbox"/> Fax		

Fill out this section for	J. Gialopsos, LCSW	T. Bodine, LCSW	T. Reif, PhD
I authorize _____ to disclose mental health information to the provider circled above, Mailing address: Day Hill Psychotherapy, 110 Day Hill Rd., Windsor, CT 06095.			
Contact Person _____	Telephone: _____		Fax: _____

The dates of service and the type(s) of information to be used or disclosed are as follows:

Dates of treatment: _____
 Medical/Clinical/Psychological/Psychiatric Information Treatment plans, background information Psychological / neuropsychological / psychosocial assessment. Other _____

The purpose of this disclosure or use is for the following reason:

Medical/Psychological treatment or follow-up Legal Disability Request of patient Other _____

I agree that a copy of this authorization will be as valid as the original. This authorization will be valid for a period of one year from the date below. I understand that I may revoke this authorization at any time by notifying the provider checked above at Day Hill Psychotherapy in writing, but if I do, it won't have any effect on actions taken before the revocation was received. I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations. I understand that my treatment or continued treatment by the provider checked above is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it.

Patient Signature (or authorized representative*) _____ **Date** _____

*Note: If you are signing as the legally authorized representative of the patient, please indicate your relationship to the patient here: Parent Guardian Other _____

HIV RELATED INFORMATION

In the event that information released constitutes confidential 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.

PSYCHIATRIC/PSYCHOLOGICAL INFORMATION

In the event that information released constitutes confidential psychiatric/psychological 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 or of using it for any purpose other than that indicated above without the specific written consent by the person to whom it pertains, or as otherwise permitted by said law.

DRUG AND ALCOHOL ABUSE RECORDS

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 confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains 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. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.