Madison Youth & Family Services
SUPPORT • COMMUNITY • EMPOWERMENT

Authorization to Obtain and/or Release Protected Health Information

Client Name _____ **Date of Birth** _____ **Client Number**_____

I hereby authorize Madison Youth and Family Services to **Release**_____ and/or **Obtain**_____ **(check one or both)** the following protected health information (hereinafter "PHI") as that term is defined in the Health Insurance Portability and Accountability Act of 1996 (hereinafter "HIPAA") on behalf of the above named client:

Requested data, check all that apply:

- ☐Treatment records
- ☐Diagnostic records
- ☐Medical and physical history
- ☐Discharge summary and aftercare recommendations
- ☐Psychological tests
- ☐Psychosocial assessment
- ☐Treatment plan
- ☐Clinical Case Notes
- ☐Laboratory tests
- ☐MY&FS billing records
- ☐Demographic data
- ☐Other Specify _____
- ☐Other Specify _____

Name of recipient: _____ **Phone Number of recipient:** _____

Address of recipient: _____

The PHI is being used/disclosed for the following purposes:

- ☐Diagnosis and continuing treatment
- ☐To enable judges, attorneys, probation/parole officers to support treatment goals or make legal decisions on my behalf
- ☐To coordinate treatment efforts with my family/concerned persons or other providers/agencies
- ☐Other _____

This form serves the dual purpose of a general authorization for the release of protected health information and a specific authorization for the release of information protected by state and federal confidentiality laws and regulations. The information to be released may contain information pertaining to psychiatric, psychological, alcohol, drug and/or HIV or AIDS testing, diagnosis or treatment.

I understand and acknowledge that use and/or disclosure may be made on behalf of MY&FS by any of its officers, members, employees, agents, or representatives while acting on its behalf. I understand and acknowledge that MY&FS will make reasonable efforts to use, disclose, and request only the minimum amount of PHI needed to accomplish the intended purpose of the use, disclosure or request, to the extent required by HIPAA. I understand that the above information is protected under Chapter 899 of the Connecticut General Statutes as well as Federal Confidentiality Regulations 42 CFR (Part 2) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. By executing this authorization, I expressly acknowledge that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected under HIPAA.

I understand and acknowledge that MY&FS will not condition treatment, payment, enrollment or eligibility for benefits on my execution of this authorization. I understand and acknowledge that I have a right to inspect and copy my PHI. I understand and acknowledge that I have a right to refuse to execute this authorization. I understand and acknowledge that such use or disclosure may result in remuneration to MY&FS. I understand and acknowledge that I have the right to revoke this authorization in writing at any time, except to the extent that MY&FS has taken action in reliance thereon. In order to revoke this authorization, I understand and acknowledge that I must send written notification expressly stating that I am revoking my authorization to use or disclose individually identifiable health information to Assistant Director, Clinical Services of MY&FS at 10 School Street, Madison, CT 06443. I understand and acknowledge that this authorization expires one year from the later of: (1) the last day MY&FS provides or renders treatment to me; or (2) the day MY&FS receives any and all payments for services rendered by it to me, whether such payments are made by me, my insurance provider, or a third party. By executing this authorization, I acknowledge that I will be provided a copy of the same by MY&FS. If at any time I lose my copy, I understand and acknowledge that I may request a copy by contacting the assigned clinician and a copy will thereafter be provided to me.

_____ _____
Printed name of client or legal representative Date

_____ _____
Signature of client or legal representative Legal relationship to the client

_____
Signature of staff

❑ Copy given to the client/legal representative ❑ Client/legal representative declined copy