Stonington Institute

Client Name: _____

DOB: _____

Place Client Record Label here

Mail or Fax to:

☐ 75 Swantown Hill Road, North Stonington, CT 06359 Fax: 860-535-9076

☐ 618 Poquonnock Road, Groton, CT 06340 Fax: 860-445-3030

Questions? Please call 860-445-3000 and ask for the Health Information Department.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Client Name: _____ Birth Date: _____

Maiden/Prior Names: _____ Current Phone #: _____

Current Address: _____ Last 4 of SS#: _____

I, (name above), hereby authorize Stonington Institute to release or request from:

☐ Self (address above)

☐ _____ (____)_____ _____

Agency/Organization Telephone Number Street Address

_____ (____)_____ _____

Name / Attention to Fax Number City State Zip Code

Via (only when released to): ☐ Mail ☐ Fax ☐ Email: _____

☐ Verbal Exchange of Information **ONLY**

I am requesting disclosure of my protected health information for the following purpose:

☐ Continuing Care ☐ Disability Determination ☐ Child Custody ☐ Personal Use

☐ Academic ☐ Legal Investigation ☐ Billing/Insurance ☐ Other: _____

Dates of Service Requested (be specific): _____

(Please write "*All Dates*", if requesting all dates of services)

☒ **I authorize the release of the following information including all records that include any substance use disorder and/or substance use disorder treatment records, or**

☐ **I authorize the release of the following information excluding all records that include any substance use disorder and/or substance use disorder treatment records,**

Only the information and records indicated below (check all that apply and /or specific if "Other is checked):

☐ Letter of Verification of Treatment/Progress in Treatment

☐ Psychosocial Assessment

☐ History and Physical

☐ Discharge Summary/Discharge Plan

☐ Dates of Admission/Discharge

☐ Physician Orders/Medication List

☐ Labs/TB results

☐ HIV Test Results and AIDS Treatment Records

☐ Other: _____

This authorization will expire on ____/____/20____. (If not indicated, authorization will expire one year from signature date)

This form must be completed in full before signing:

_____ _____ _____

Client's signature Parent/Legal Guardian signature (if applicable) Relationship to Client

_____ _____

Witness signature/Credentials Date Signed

This authorization is intended to allow "Stonington Institute" to release information, both written and verbal, for the specific purpose and life of the release and in the best interest of the patient. This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Any information protected by Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2) is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure.

You have the right to revoke this authorization, by written request, at any time. Exceptions to this can be reviewed in the Notice of Privacy Practices. The revocation will not apply to information that has already been released in response to this authorization. Once the above information is disclosed, it may be subject to redisclosure by the recipient and may no longer be protected by federal regulations. Your right to inspect and receive a copy of the information that is to be disclosed. Choosing not to sign this authorization will prevent the above indicated purpose from being achieved. Treatment or payment for services is not conditioned on signing this authorization. A fee may be associated with the copying of my information in the processing of this request.

_____ _____

Revocation Signature Date/Time