Cornell Scott Hill Health Corporation

428 Columbus Ave., New Haven, CT
P:(203) 503-3140/Fax: (203) 503-3143

Authorization for Access / Release of Health Information

Patient Information
Name: _____Maiden/Other: _____
DOB: _____ Phone: _____ Work: _____
Address: _____
City: _____ State: _____ Zip: _____

Recipient of Information: I authorize CS-HHC to ☐ **DISCLOSE** and/or ☐ **RECEIVE protected** health information to/from:

Name / Organization: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
Method: ☐ Mail ☐ Fax ☐ Pick-up **(ID WILL BE REQUIRED)**

CS-HHC reserves the right to charge reasonable copying/mailing fees per CT law (§20-7c[d]).

Purpose of Request: Specify the purpose of this request.
☐ Personal Use ☐ Coordination of Care ☐ Legal ☐ Insurance ☐ Disability
☐ Workers' Comp ☐ Transfer of Care ☐ Other: _____

Protected Health Information to be Disclosed:
☐ **All records** maintained by CS-HHC or
☐ **Specific records** pertaining to **(check all that apply):**
☐ Medical ☐ Billing ☐ Dental ☐ Immunization ☐ Other: _____
with **Dates of Service:** From _____ to _____

Sensitive Information (Initial Required): INITIAL next to each item below if you AUTHORIZE the release of sensitive health information related to the testing, diagnosis and treatment for:

HIV/AIDS: ☐ **SUBSTANCE USE DISORDERS:** ☐

MENTAL/BEHAVIORAL HEALTH: ☐

BY SIGNING BELOW, I UNDERSTAND: This authorization is valid for **one (1) year** from the date signed below **UNLESS** I revoke this authorization by providing a signed, written notice of such revocation to CS-HHC. I understand information released may be re-disclosed and no longer protected by federal privacy laws. Signing is voluntary and

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not a condition of treatment. A parent/guardian must sign for minors unless CT law permits minor consent. If sensitive info applies to patients age 13+, the minor must sign.

Signatures

PRINT AND DATE
Patient / Authorized Representative:

_____
DATE

SIGN AND DATE
Patient / Authorized Representative:

_____
DATE

PRINT AND DATE:
Witness / Staff _____
DATE

SIGN AND DATE:
Witness / Staff _____
DATE

If Representative: Relationship / Authority:
_____