Fair Haven Community Health Care

PLEASE RETURN REQUEST TO

Mail: Fair Haven Community Health Care
Attn: Health Information Management
374 Grand Avenue
New Haven, CT 06513
Phone: (203) 777-7411
Email: medicalrecords@fhchc.org
Fax: (203) 752-5145

AUTHORIZATION FOR ACCESS/RELEASE OF INFORMATION

PATIENT INFORMATION

Patient's Name:_____ **Maiden/Other Name:**_____

Patient's Address:_____ **Date of Birth:**_____

City:_____ **State:**_____ **Zip:**_____ **Phone:**_____

I authorize Fair Haven Community Health Care to ☐**RELEASE** and/or ☐**OBTAIN** my medical record information as specified below:

REQUESTER INFORMATION

Name:_____ **Phone:**_____

Address:_____ **Fax:**_____

City:_____ **State:**_____ **Zip:**_____

Method of Disclosure:

☐Mail ☐Fax ☐Pick-up ☐Verbal

FHCHC reserves the right to charge a reasonable fee for the cost of producing and mailing copies under Connecticut State Law.

Purpose of Request

☐Personal Use ☐Coordination of Care ☐Legal ☐Disability

☐Workers Comp ☐Insurance ☐Transfer of Care ☐Other: _____

INFORMATION TO RELEASE

Dates of Service

from _____ to _____

☐All information maintained at any time by FHCHC **OR** the following limited information:

☐Medical Records
☐Billing
☐Dental Records
☐Immunization Record
☐Other: _____

Sensitive Information Authorization

Federal and Connecticut State law require your specific authorization to release certain health information. The following information will **NOT be released without your specific authorization.** For more detailed information on your rights to privacy, please refer to our Notice of Privacy Practices.

Types of Sensitive Information	Initial	Dates of Service
Disclosure of Behavioral Health/Psychiatric*		
Disclosure of HIV/AIDS-STD		
Disclosure of Alcohol/Drug Use Treatment*		
Disclosure of Reproductive Health Care		

If this is an authorization for psychotherapy notes or Alcohol/Drug Use (Substance Use Disorder – SUD) counseling notes,* it may **NOT be combined with an authorization for any other type of health information per Federal and State law. A separate written authorization is needed.

AUTHORIZATION FOR RELEASE

By signing below, I acknowledge the following:

- This authorization is valid for one year from the date below. I understand that after I have signed this form, I may cancel (revoke) this authorization at any time by contacting FHCHC in writing. Cancellation of this authorization will not apply to information that has already been released based on this authorization.
- I understand that some information disclosed under this authorization may be subject to redisclosure by the recipient, while other information, including the above listed sensitive information, may remain protected by federal or state law and may not be redisclosed without additional authorization, except as permitted by law. For example, 42 CFR part 2 prohibits unauthorized use or disclosure of alcohol/drug use treatment.
- I understand that this authorization is voluntary and my treatment by FHCHC will in no way be conditioned on whether or not I sign this authorization and that I may refuse to sign it.
- The parent or legal guardian must sign this authorization if the patient is a minor (under age 18) unless the records relate to treatment(s) for which the minor may provide consent under CT state law. If HIV, Behavioral Health, Drug/Alcohol, and/or Reproductive Health Care Service is included for a patient age 13 or older, the minor must sign as described above.

_____ _____ _____

Signature of Patient or Authorized Representative Printed Name Date

_____ _____ _____

Signature of Witness Printed Name Date

Rev. 1/2026

If signed by the patient's authorized representative, describe the legal authority of the representative to act on behalf of the patients and attach legal documentation: _____