

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: <input type="checkbox"/> Mail <input type="checkbox"/> Fax <input type="checkbox"/> Pick-up <input type="checkbox"/> Verbal
<i>FHCHC reserves the right to charge a reasonable fee for the cost of producing and mailing copies under Connecticut State Law.</i>		
Purpose of Request	<input type="checkbox"/> Personal Use <input type="checkbox"/> Coordination of Care <input type="checkbox"/> Legal <input type="checkbox"/> Disability <input type="checkbox"/> Workers Comp <input type="checkbox"/> Insurance <input type="checkbox"/> Transfer of Care <input type="checkbox"/> Other: _____	

INFORMATION TO RELEASE	Dates of Service from ___/___/___ to ___/___/___	Sensitive Information Authorization			
	<input type="checkbox"/> All information maintained at any time by FHCHC OR the following limited information: <input type="checkbox"/> Medical Records <input type="checkbox"/> Billing <input type="checkbox"/> Dental Records <input type="checkbox"/> Immunization Record <input type="checkbox"/> Other: _____	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: <ul style="list-style-type: none"> 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.
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 Signature of Patient or Authorized Representative

 Printed Name

 Date

 Signature of Witness

 Printed Name

 Date

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: _____