☒ **Health Services 860.231.5530 FAX 860.231.6794**
☐ **Counseling and Wellness Center 860.231.5530 FAX 860.231.6794**
☐ **Student Accessibility Services 860.231.5481 FAX 860.512.7293**

REQUEST AND AUTHORIZATION TO EXCHANGE INFORMATION

I authorize USJ to release my information to or obtain my information from the individual(s) named below:

Patient's Name:		Name if different at the time of visit/treatment:
Date of Birth:	ID#	Telephone #:
☒ Release Information To:		☒ Obtain Information From:
Name:		Name: Health Services
Address:		Address: Little Red House, 1678 Asylum Avenue
City, State, Zip:		City, State, Zip: West Hartford, CT 06117
Telephone:		Telephone:860-231-5530
Fax:		Fax:860-231-6794
Comments: **Students/others: Please fill in the 'release to' even if we are releasing to you.**		

Purpose of this request is for:

☐ Personal	☐ Treatment	☐ Legal
☐ Insurance	☐ Disability	☐ Transfer
☐ Other:		

The type of information to be released or obtained is as follows (<u>check</u> the appropriate boxes and include other information where indicated):

☐ Immunizations	☐ Radiology Results	☐ Laboratory Results
☐ Information for Clinical Program Sites	☐ Medical History/Physical Examination/Office Notes	☐ Complete Health Record
☐ Other:		

*****If drug/alcohol abuse, psychiatric/mental health, or HIV/AIDS/STD Related Records is to be included, you <u>must check each box below</u>.*****

☐ Drug/Alcohol Abuse* ☐ Psychiatric/Behavioral Health ☐ HIV/AIDS related information

However, if you do not wish to disclose <u>all</u> of your drug/alcohol abuse information, please indicate what information to <u>EXCLUDE</u> here: _____.

☐ Include all records from outside agency/providers except _____
☐ Do not include any records from outside agency/provider

Dates of Service: ☐ All past records until today **<u>OR</u>** From the dates _____ to <u>present</u>.

I the undersigned hereby authorize USJ to disclose or obtain the above personal health information as I have indicated. I also understand that I may revoke this consent at any time, and that if I revoke this authorization, I must do so in writing and present my written revocation to USJ. I understand that this revocation will not apply to information that has already been released in response to this authorization. Further, I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

I understand that signing this authorization is voluntary and that Health Services/University cannot condition my treatment based on whether I sign this authorization.

This authorization expires one year from the date of signing, unless I indicate a different expiration event or this date: _____

_____ _____
Patient's/Personal Representative Signature Date
Electronic signature not accepted

NOTICE

This information is released for your professional use and is privileged. Do not duplicate without the express consent of the patient.

Psychiatric Records and Communications

In the event that information released constitutes privileged psychiatrist-patient communications:

> "The confidentiality of this record is required under chapter 899 of Connecticut General Statutes. This material shall not be transmitted to anyone without the written consent or other authorization as provided in the aforementioned statutes." (Conn. Gen. Stat. § 52-146i).

Drug and Alcohol Abuse Records

In the event that information releases is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records regulations:

> "This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65." (42 C.F.R. § 2.32).

HIV Related Information

In the event that information released constitutes confidential HIV related information protected under Connecticut Law:

> "This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose." (Conn. Gen. Stat. § 19a-585(a)).