Authorization to Release or Obtain Information for Behavioral Health

Name of Patient: _____ DOB: ___/___/___

I hereby authorize **New England Wellness Center LLC** to release/obtain all medical information with respect to the treatment of the above-referenced patient, including information relating to diagnosis or treatment of mental illness or drug or alcohol abuse and/or confidential HIV-related information.

The Name/Specific Identification of Persons to Whom Disclosure: PCP / SCHOOL / THERAPIST / OTHER

Records may be released to: ☐ **Obtained from** ☐ :

Name: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Indicate Delivery Preference (select one)

☐ Mail ☐ On-site pick up ☐ Email: _____ ☐ Fax: _____

Description of the Information to be Used or Disclosed:

☐ Personal ☐ New Physician ☐ Social Security Disability ☐ Care Coordination
☐ Primary Care Physician ☐ Medical Ins. Claim ☐ Life Insurance ☐ Assessment
☐ Consultation ☐ Workers' Comp ☐ Attorney ✔ Other: **COLLABORATION**

Description of the Information to be Used or Disclosed: Specific date(s) of treatment: **Through episode of care**

☐ Abstract (face sheet, history and physical, evaluations, operative report, discharge summary, consultation, laboratory, radiology)
☐ Test Results (lab, radiology, cardiology, neurology, respiratory)
☐ Therapy Notes (med visit note, progress note, physical, occupational, speech, chemo, radiation)
☐ School Records: (attendance records, IEPs, triennial testing, special education evaluation, 504 plans, FBA reports, discipline)
☐ Drug and Alcohol Record
☐ Complete Emergency Room Record
☐ Complete Record - specify dates of care: _____ to _____
✔ Other: COLLABORATION

I understand that New England Wellness Center LLC will not condition treatment, payment, enrollment or eligibility for benefits based on my signing this Authorization. I acknowledge that I am signing this Authorization freely, and no one has coerced or pressured me to sign the Authorization.

I understand that I may revoke this Authorization at any time by providing written notice to New England Wellness CenterLLC. I understand that I may not be able to revoke this authorization if the stated provider has taken action in reliance on the Authorization, or if the Authorization was obtained as a condition of obtaining insurance coverage.

I understand that the Protected Health Information disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by the Federal Privacy Regulations.

I also understand that if the Protected Health Information that is disclosed under this Authorization is confidential HIV/AIDS related information or alcohol or drug abuse related information, the recipient may not re-disclose that information under Connecticut State Law.

Unless otherwise revoked, this Authorization will expire on the following date, event, or condition: through ____/_____/_____. If I fail to specify an expiration date, event or condition, this Authorization will expire in **one year**.

_____ _____
Signature of Patient or Person granting Authorization on behalf of patient Date