

Authorization for Use or Disclosure of Protected Health Information

Name of Patient	_____		
Date of Birth	_____	YNHH Medical Record #	_____
Daytime Phone #	_____	Evening Phone #	_____
Address	_____		
City	_____	State	_____
		Zip Code	_____

I hereby authorize Yale School of Medicine to use or disclose my protected health information as indicated below to:

Name	_____		
Daytime Phone #	_____	Fax #	_____
Address	_____		
City	_____	State	_____
		Zip Code	_____

Information to be released:

- From & To Dates _____
- History and physical exam _____
- Lab report _____
- X-ray report _____
- Consultation report _____
- Other _____

Purpose of Disclosure:

- | | |
|--|---|
| <input type="checkbox"/> Changing physicians | <input type="checkbox"/> Second Opinion |
| <input type="checkbox"/> Continuing Care | <input type="checkbox"/> Legal |
| <input type="checkbox"/> At my (patient) request | <input type="checkbox"/> Insurance |
| <input type="checkbox"/> Workers' Compensation | <input type="checkbox"/> School |
| <input type="checkbox"/> Other _____ | |

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am specifically authorizing the release of information relating to:

- Substance Abuse (including alcohol/drug abuse)
- Mental Health
- Psychotherapy Notes
- HIV related information (including AIDS related testing)

The confidentiality of this record is required under Chapter 899 of the Connecticut General Statutes, as well as, Title 42 of the United States code. This material shall not be transmitted to anyone without written consent or authorization as provided in these statutes.

X _____
Signature of Patient or Legal Guardian Date

- I understand that this authorization will expire two years from my last date of service visit. A photocopy of this form will be considered as valid as the original.
- I understand that I may revoke this authorization at any time by notifying The YSM Deputy Privacy Officer at the address indicated below, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.

YSM Deputy Privacy Officer
 Yale School of Medicine
 300 George Street, 6th Floor
 P.O. Box 9805
 New Haven, CT 06535-9805
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
- My health care and payment for my health care will not be affected if I do not sign this form.
- I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
- I understand that I will get a copy of this form after I sign it.

By signing below, I acknowledge that I have read and understand this Authorization.

Signature of Patient	OR	Parent/Legal Guardian/Authorized Person
Date		Date
		Relationship to Patient

Records Received By _____ Date _____

For Office Use Only

Date Request Filled _____	By _____	_____
YNHH MRN _____		IDX Account # _____
Identification Presented _____		Fee Collected _____

Form #: YSM HIP11

Original Date of Form: Effective Date: April 14, 2003

Revised Date: March 9, 2007