CENTER FOR
Behavioral Wellness

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HIPAA AUTHORIZATION TO OBTAIN AND/OR RELEASE PROTECTED HEALTH INFORMATION

Name (First, MI, Last): _____ Date of Birth _____/_____/_____

Phone Number (_____) _____

I, or my authorized representative, authorize disclosure of my Protected Health Information as follows:

CENTER FOR BEHAVIORAL WELLNESS TO OBTAIN:	CENTER FOR BEHAVIORAL WELLNESS TO DISCLOSE:
I authorize: _____ To disclose health information to: Center for Behavioral Wellness 925 Sullivan Avenue, Unit 2 South Windsor, CT 06074 Phone: 860-432-7771 Fax: 860-432-7774	I authorize Center for Behavioral Wellness to disclose health information to: Name: _____ Address: _____ _____ Phone: _____ Fax: _____

Method of Release: ☐ Fax ☐ Verbal ☐ Mail ☐ For Review Only

Specific information to be released, requested, or discussed:

Date(s) of Treatment: _____

☐ Complete Medical Record (Includes Mental health, Alcohol/Drug/Substance, Genetic, HIV/AIDS, & Medication History)

☐ Contact/Discuss Treatment ☐ Notification of Treatment ☐ Progress Notes ☐ Lab/Test Results ☐ Genetic Testing ☐ Billing Reports

☐ Initial Psychiatric/Psychological History/Evaluation ☐ Medications/Pharmacy ☐ Other: _____

Initial _____ Date ___/___/___ Alcohol or Drug Use/Abuse Treatment Initial _____ Date ___/___/___ HIV Status or Treatment

This information is to be used for the following purpose(s):

☐ Continuing treatment, care and continuity of care ☐ Disability ☐ Transfer of care ☐ Care coordination or case management

☐ Billing, collection or payment of claims ☐ Patient Request ☐ Other: _____

This authorization is valid one year from the date this authorization is. This authorization may be revoked at any time through written request provided to this office by the client.
I have had an opportunity to review and understand the content of this authorization form. By signing this form, I am authorizing Center for Behavioral Wellness and associated providers to send and/or receive protected health information and that it accurately reflects my wishes. No third party medical information will be released by Center for Behavioral Wellness for any medical record request received.

Signature of Client/Parent/Legal Representative Date Print Name

If not signed by the patient, indicate relationship of authorizing person to patient:

☐ Parent or guardian of minor child

☐ Guardian or conservator of conserved patient

Witness Date Print Name