Yale University School of Nursing Form

Authorization for Use or Disclosure of Protected Health Information

PATIENT NAME:_____
LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH:_____-_____-_____ MEDICAL RECORD #:_____
MO DAY YR

ADDRESS:_____ CITY:_____STATE:____ZIP:_____

DAY PHONE: _____ EVENING PHONE: _____

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

NAME: _____

ADDRESS: _____ CITY:_____STATE:____ZIP:_____

PHONE:_____ FAX:_____

INFORMATION TO BE RELEASED:

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

PURPOSE OF DISCLOSURE:

- ❑ Changing physicians
- ❑ Continuing care
- ❑ At my (patient) request
- ❑ Workers' Compensation
- ❑ Other:_____
- ❑ Second Opinion
- ❑ Legal
- ❑ Insurance
- ❑ School

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

1. 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.
2. I understand that I may revoke this authorization at any time by notifying Yale School of Nursing Deputy Privacy Officer 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.
3. 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.
4. My health care and payment for my health care will not be affected if I do not sign this form.
5. 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.
6. 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 DATE
OR PATIENT'S AUTHORIZED REPRESENTATIVE

If NOT SIGNED BY PATIENT, INDICATE RELATIONSHIP TO PATIENT OR OTHER AUTHORITY TO ACT:_____

_____ _____
RECORDS RECEIVED BY DATE

FOR OFFICE USE ONLY

DATE REQUEST FILLED:_____ BY: _____

IDENTIFICATION PRESENTED: _____ FEE COLLECTED: $_____