Authorization For Use or Disclosure of Protected Health Information
East Granby Family Practice, L.L.C.

13 Church Road
P.O. Box 518
East Granby, CT 06026
Attention: HIPAA Compliance Team
Phone: (860) 653-4526
Fax: (860) 653-5209

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Connecticut law, this practice may use or disclose your individually identifiable health information with your authorization except as provided in our Notice of Privacy Practices. You completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purposes for the disclosure.

I hereby authorize East Granby Family Practice to use and disclose health information concerning:

_____

(Patient name) Date of Birth

(Address) _____

Description of health information to be used or disclosed *(If this is an authorization for the use or disclosure of psychotherapy notes, it may not be combined with an authorization for the use and disclosure of any other type of health information except other psychotherapy notes)*:

_____
_____
_____
_____

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

Specify Name: _____

Address: _____
_____
_____

Phone: (_____)_____ Fax: (_____)_____

The information will be used or disclosed for the following purpose(s) only:

- ☐ Other insurance ☐ Legal process ☐ At the request of the individual or individual's representative
- ☐ Assist in the grievance/appeal process ☐ Assessment/referral/supervisory referral
- ☐ Other (specify):_____
_____

(Include one of the following, as appropriate:)

- ☐ I understand that my health care treatment or benefits will nor be affected whether I sign or do not sign this for ***or***

I understand that if I do not sign this form:

- ☐ I cannot participate in this research-related treatment.
- ☐ My health plan may enroll me or make me eligible for benefits.
- ☐ My physician will nor perform the expert, employment, life insurance or other physical or medical evaluation which would otherwise be performed solely for the purpose of disclosure to a third party.

Effect of Refusal to Sign Authorization

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 may revoke this authorization at any time by notifying this medical practice in writing. My revocation will nor affect actions taken by this medical practice prior to its receipt.

I understand that, if the recipient of the information is not a health care provider or health plan covered by the federal Privacy Rule, the information used or disclosed as described above may be redisclosed by the recipient and no longer protect by the Privacy Rule. 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.

This authorization is effective now and will remain in effect until _____
(expiration event or date).

I understand that I have the right to receive a copy of this authorization

Signed: _____ Dated: _____

Print name: _____

If not signed by the patient, please indicate relationship: _____