Authorization for Disclosure of Health Information

To The Treehouse Center for Children and Families, LLC
Phone: 860-684-5015 Fax: 860-684-3749

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and Connecticut law, this practice may not use or disclose your individually identifiable health information without your authorization except as provided in our Notice of Privacy Practices. Your completion of this form indicates that you are giving permission for the uses and disclosure described below.

I hereby authorize _____ to disclose the following health information:

☐ Growth curves ☐ Office visits ☐ Lab data
☐ Consult notes ☐ Hospital records ☐ Immunizations

for (child's name) _____ DOB:_____

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 authorizing such information to be disclosed.

This health information may be disclosed to and used by The Treehouse Center for Children and Families for the purposes of medical treatment and decision making. It remains in effect until the authorizing person terminates this therapeutic relationship.

This information indicated above should be faxed to this office in its entirety along with a cover page indicating the number of pages that should be received. If this is not possible, please call our office to make other arrangements.

Effect of refusal to sign this 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 not 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 may be redisclosed by the recipient and may be no longer protected the 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-or AIDS-related information, and psychiatric/mental health information.

I understand that I have the right to receive a copy of this authorization.
Signature _____ Date _____

Name _____ Phone _____

Relationship to patient _____