

Authorization for the Release of Information

SECTION A: I _____ authorize the disclosure of my personal health information as described in Section B below. I understand this authorization is voluntary and made to confirm my directions. I hereby give my permission to Behavioral Health Connecticut, LLC to disclose my personal health information in the manner described herein.

Member's Name: _____
(Please Print)

Address: _____

Member's DOB: _____ **ID Number:** _____

SECTION B: Personal Health Information to be disclosed: Describe the personal health information you are authorizing to be used and/or disclosed:

Person(s) Authorized to Receive and Use: Provide the following information of the individual (s) to whom you are authorizing Behavioral Health Connecticut, LLC to disclose or let use the personal health information described above:

Representative(s) Name/Relationship:

Address: _____

Phone No.: _____

Right to Revoke: I may revoke this authorization at any time of my choosing. If I do not revoke it, this authorization will expire one (1) year after the date on which the authorization is signed. To revoke the authorization, I will contact **HIPAA Privacy Office, % Behavioral Health Connecticut, LLC, P.O. Box 775, Middletown, CT 06457.**

SIGNATURE:

I, _____, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to Behavioral Health Connecticut (BHC). I understand that, by signing this form, I am confirming my authorization that BHC may use and/or disclose to the person or persons named above my protected health information described in Section B of this form.

Signature: _____ **Date:** _____

**Authorization for Release of Information Form (*Authorization Form*)
INSTRUCTIONS**

This form is to be completed by members who wish to allow other individuals to receive information about their medical or claims records.

- The *Authorization Form* is valid for one year from the date you sign the form.
- You will need your membership card to complete the *Authorization form*.

Section A

Please print, in the spaces provided, the member's name, address, date of birth, and insurance ID number. Your ID number may be your social security number.

Section B

In the "**Personal Health Information to Be Disclosed**" section, write the specific personal health information to be released. For example, "The medical records related to a particular episode of care (i.e. June 2004 – July 2004)," or "All my medical records."

In the "**Person(s) Authorized to Receive and Use**" section, specify the name(s) of the individual and their relationship to you, to whom you are releasing the information. For example, "my broker John Doe," "my granddaughter Jane Doe." Also, please provide their address and phone number. This information will be used to confirm the identity of the individual requesting the information.

Signature Section

Please remember to sign and date the form before sending it in or we will not be able to use it.

Please mail or fax the completed Authorization for Release of Information Form to the address or number noted below.

**HIPAA Privacy Office
Behavioral Health Connecticut, LLC
P.O. Box 775
Middletown, CT 06457**

Fax: (860) 704-6212