Authorization for Use or Disclosure of Protected Health Information

Windham GI, LLC

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Privacy Officer: Office Manager- Immediate Supervisor of Privacy Policies

As required by the Health Insurance Portability and Accountability Ace of 1996 (HIPPA) 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 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 fully 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 purpose for the disclosure.

Patient Name *(please print)*: _____ **D.O.B**.:_____
(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.)

_____All Medical Records _____Labs only _____Radiology _____Other:_____

_____Office Notes: Dates of service: _____

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 *BY*: (Name and address of person/entity to disclose health information.)

Name: _____*Address:*_____ *Phone/Fax:* _____

This health information may be disclosed *TO*: (Name and address of person/entity to receive the health information.)

Name: _____*Address:*_____ *Phone/Fax:* _____

- This information may be use and disclosed only for the following purpose: At the request of the individual.
- *I understand that my health care treatment of benefits will not be affected whether I sign or do not sign this form.*
- This authorization will be valid for a period of one year from the date below.
- 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 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 above may be redisclosed by the recipient and no longer protected 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.

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

Signature of Patient: _____ Date: _____

If not signed by the patient please indicate relationship: _____