Child Guidance Center of Southern CT (CGC) has formed an alliance with Community Health Center, Inc. (CHC).
Your CGC providers will continue to provide your care at the same location(s).
CHC will provide billing and administrative services. Please let the front desk or your provider know of any questions.

Authorization to Release or Obtain Health Information

Patient Name: _____ Previous Name: _____

Date of Birth: ____/____/____ Phone (Home) #: (____) ____-____ Phone (Mobile) #: (____) ____-____

☐ **I authorize CHC to RELEASE my info TO:** Name:_____Address:_____

City:_____ State:____ ZIP: _____ Phone #: (____) _____-_____ Fax #: (____) _____-_____

OR ☐ **I authorize CHC to OBTAIN my info FROM:** Name:_____Address:_____

City:_____ State:____ ZIP: _____ Phone #: (____) _____-_____ Fax #: (____) _____-_____

OR ☐ **If releasing information to ME, my medical records should be released via:**

☐ Mail ☐ Fax #: (____) ____-____ ☐ Pick Up ☐ Email: _____

Address:_____ City:_____ State:_____ ZIP: _____

All medical records requests must be processed by the Medical Records Department.

The type of info to be released or obtained is as follows (check the appropriate boxes and include other info where indicated):

☐ Progress notes ☐ Consultation notes ☐ Complete health record *(No telephone encounters)*
☐ Dental records, including x-rays ☐ Labs ☐ Complete health record *(With telephone encounters)*
☐ Immunizations ☐ X-ray, CT Scan, MRI, US results ☐ Other: _____

If drug/alcohol abuse, psychiatric/mental health, or HIV/AIDS related information is to be included (check each box below):

☐ Drug/Alcohol Abuse* ☐ Psychiatric/Behavioral Health ☐ HIV/AIDS related information

*However, if you do not wish to disclose all of your drug/alcohol abuse information, please indicate what information to **exclude below**:

_____

Specified date(s) of service:

☐ **From the dates** _____**to** _____ **OR** ☐ **From start of care to present OR** ☐ **Last three (3) years** (from date below)

I am signing this Authorization for the following reason:

☐ Legal ☐ Transferring Care ☐ Coordinating Care ☐ Relocation ☐ Other: _____

This authorization will **expire 90 days** from the date on which it was signed, unless I indicate a different expiration event or date below:

_____

I understand that I have a legal right to revoke this authorization at any time/ I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Community Health Center, Inc. (CHC) Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to his authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

I understand authorizing the use or disclosure of the information identified is voluntary. I can refuse to sign this authorization. I need not sign this form to ensure healthcare treatment. I can contact the Privacy Officer if I have questions about my health information.

By signing below, I acknowledge that I have read and understand this authorization form and that CHC has **30 days** to fulfill my request.

Signature of Patient or Legal Representative:_____ Date: _____

Print Name:_____ Relationship to Patient: _____