Authorization for Disclosure of Health Information

From 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 The Treehouse Center for Children and Families, LLC to disclose the following health information:

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

for (child's name) _____ DOB:_____
to be sent to: _____
_____
_____

In the form of: ☐ Flash Drive ($10) ☐ Paper/Mail (45¢ per page) ☐ Fax (Free)*

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.

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 _____

*Please note: Most offices will not accept large documents by fax. Please inquire before choosing this option.