Connecticut Medical Home Initiative for Children and Youth with Special Health Care Needs*

Authorization for Release of Protected Health Information Form

I/We the undersigned hereby authorize any and all physicians, medical providers, medical facilities, therapists, schools, early intervention services, medical insurance companies, and any other health care professional or agency involved in my child's care to communicate with and/or release information, which may include information relating to medical, psychiatric, alcohol, and drug abuse, HIV/AIDS, Sickle Cell Disease, to any or all of the following:

Connecticut Medical Home Initiative for
Children and Youth with Special Health Care Needs
Eastern
United Community and Family Services, Inc.
47 Town Street
Norwich, CT 06360

Connecticut Medical Home Initiative for
Children and Youth with Special Health Care Needs
North Central
Connecticut Children's Medical Center
282 Washington Street
Hartford, CT 06106

Connecticut Medical Home Initiative for
Children and Youth with Special Health Care Needs
Northwest
St. Mary's Hospital, Inc.
95 Scovill St., Pavilion B, 2nd Floor
Waterbury, CT 06706

Connecticut Medical Home Initiative for
Children and Youth with Special Health Care Needs
South Central
Family Centered Services of Ct
235 Nicoll e St
New Haven, CT 06511

Connecticut Medical Home Initiative for
Children and Youth with Special Health Care Needs
Southwest
Stamford Hospital
30 Shelburne Road
Stamford, CT 06904

Connecticut Medical Home Initiative for
Children and Youth with Special Health Care Needs
CT Medical Home Initiative at FAVOR
185 Silas Deane Highway
Wethersfield, CT 06109

United Way of Connecticut 2-1-1 Infoline Child Development Infoline
1344 Silas Deane Highway
Rocky Hill, CT 06067

CT Medical Home Initiative for CYSHCN at
Generations Family Health Center Inc
42 Reynolds St, Danielson, Ct 06239
40 Mansfield Ave Willamantic,Ct 06226

Child's Name: _____ Date of Birth:

mm	dd	yy

Please specify the time period for the information you authorize to be disclosed:

☐ All information maintained at any time by the discloser, or

☐ Information maintained by the Discloser from:

mm	dd	yy	to:	mm	dd	yy

For the purpose of evaluation and/or care coordination --

The confidentiality of this record is required under Chapter 866 of the Connecticut General Statutes. The material shall not be transmitted to anyone without written consent or authorization as provided in the aforementioned statutes.

I may revoke this authorization at any time, except to the extent action has been taken in reliance thereon. This authorization, unless expressly revoked earlier, **expires on one year from date signed**. I understand that the information released here may be subject to re-disclosure by the recipient and may no longer be protected by the above-named facilities' privacy practices or applicable privacy law.

Signature: _____ Date: _____

Signature: _____ Date: _____

If signed by the patient's personal representative, describe the legal authority of the representative to act on behalf of the patient:

_____

I acknowledge the offer and/or receipt of the Notice of Privacy Practices from all current providers of care. (HIPAA)

Signature: _____ Date: _____

*The Connecticut Medical Home Initiative for Children and Youth with Special Health Care Needs is a program supported by the State of Connecticut Department of Public Health. Information is available on their website at www.ct.gov/dph.

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