UNIVERSITY OF HARTFORD

Student Health Services Department – Partnered with HARTFORD HEALTHCARE
200 Bloomfield Avenue * West Hartford, CT 06117 * Phone: 860-768-6601 * Fax: 860-768-5140

AUTHORIZATION TO DISCLOSE/OBTAIN HEALTH INFORMATION

I, the undersigned patient or legal representative thereof hereby authorize the use and disclosurer of my health information by the University of Hartford Student Health Services Department and its respective employees, agents, and subcontractors as described below.

I understand that this Authorization is voluntary. I understand that I may refuse to sign or may revoke this Authorization at any time and for any reason. I also understand that my services, treatment, payment enrollment or eligibility for benefits will not be affected by my signing, refusing to sign or revoking this Authorization.

Patient Name: _____ Date of Birth: _____ Student id#: _____

Fill out Below to Disclose/Obtain

I authorize _____ to disclose/obtain health information to: _____
Facility Name

Address: _____

Telephone #: _____ Fax #: _____

Method of Disclosure: ☐ Mail ☐ Pick-up ☐ Patient Portal ☐ Fax ☐ E-mail (Not secure) ☐ Other (Specify):_____

The health information covered by this Authorization to be used or disclosed are as follows:

☐ My Complete Medical Record

☐ The following informaiton only: _____

_____

In addition to the information above, I specifically authorize the use and/or disclosure of the following health information:

☐ Information related to mental health treatment or psychiatric conditions* Initials:_____

☐ HIV/AIDS-related informaiton** Initials:_____

☐ Genetic testing information Initials:_____

☐ Reproductive Health*** Initials:_____

☐ Information related to alcohol and drug use**** Initials:_____

This Authorization shall apply to all health information specified above during the following time period:

☐ All information maintained by the University of Hartford Student Health Services Department

☐ Information from / / until / /

The purpose of this disclosure or use is for the following reason(s):

☐ At my request ☐ Other_____

This Authorization will expire on (date)_____. If a date is not completed, this Authorization will expire one year from the date of signature below. I understand that I may revoke this Authorization at any time; however, that revocation cannot take back any uses or disclosures already made in reliance on this Authorization.

- I understand that under applicable law, the information disclosed under this Authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal or state privacy laws and regulations or the University of Hartford Student Health Services Department privacy policies. However, I also understand that federal and state law may prohibit the re-disclosure of information related to reproductive health care, HIV/AIDS, mental health treatment or psychiatric disorders, genetic testing, and/or alcohol or drug abuse without my prior authorization in each case.
- I understand that I may inspect or copy the information to be used or disclosed under this Authorization.
- I understand that I have the right to receive a copy of this Authorization.
- I understand that I have the right to refuse to sign this Authorization.

This Authorization does not authorize disclosure of my health information to any person or entity other than the entity named above and its respective employees, agents and representatives. This Authorization can be sent to and written revocation or termination notices may be mailed to: University of Hartford, Student Health Services, 200 Bloomfield Ave, West Hartford, CT 06117; Healthser@hartford.edu or fax# (860) 768-5140.

_____	_____	_____
Signature of Patient or Legal Representative	Date	Phone Number

Relationship to patient: ☐ Self ☐ Parent ☐ Guardian ☐ Conservator ☐ Power of Attorney ☐ Administrator/Executor of Estate

If signed by the legal Representative, attach appropriate documentation to verify authority.

NOTICES TO RECIPIENT OF INFORMATION:

***MENTAL HEALTH INFORMATION**
In the event that information released constitutes confidential psychiatric information protected under Connecticut Law: This information has been disclosed to you from records whose confidentiality is protected by state law. State law Prohibits you from making any further disclosure of it or of using it for any purpose other than that indicated above without The specific written consent by the person to whom it pertains, or as otherwise permitted by said law.

****HIV RELATED INFORMATION**
Under state law, records containing HIV information are confidential and cannot be further disclosed unless the person identified in the records provides express written consent for such disclosure, or as otherwise permitted by state law. A general authorization for the release of medical or other information is not sufficient for express written consent purposes.

*****REPRODUCTIVE HEALTH CARE SERVICES INFORMATION**
In the event that information released constitutes reproductive health care services information protected under Connecticut Law: This information has been disclosed to you from records whose confidentiality may be protected by state law. A patient, or the patient's conservator, guardian, or other authorized representative has the right to withhold written consent to release this information, unless the law permits the release of reproductive health care services information without written consent.

******DRUG AND ALCOHOL ABUSE RECORDS**
Substance abuse records contain information that is protected by the Federal confidentiality rules at 42 C.F.R. Part 2 ("Federal rules"). The Federal rules prohibit you from further disclosing any of this information unless the person identified in the information provides express, written consent for such release or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is not sufficient for express written consent purposes. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.