Yale University Health Services
17 Hillhouse Avenue
P.O. Box 208237
New Haven, CT 06520-8237
Phone: (203)432-0062
Fax: (203)432-1102

Name: _____
MRN#: _____
DOB: _____

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I herby authorize _____ to use or disclose my protected health information as indicated below to:

Yale University Health Services
P.O. Box 208237
17 Hillhouse Avenue
New Haven, CT 06520-8237
ATTN: Medical Records Department

INFORMATION TO BE RELEASED:

☐ Immunization _____
☐ Physical and/or OB/GYN exam _____
☐ X-Ray report _____

☐ Notes from (date) _____to_____

☐ Prescription Information from (date) _____to_____
☐ Other: (Please Specify) _____
_____

I specifically authorize the release of information relating to:

☐ Substance Abuse (Including alcohol/drug abuse)
☐ Mental Health
☐ Psychotherapy Notes
☐ HIV related information (AIDS related testing)

The confidentiality of this record is required under Chapter 888 of the Connecticut General Statutes as well as Title 42 of the United States code. This material shall not be transmitted to anyone without written consent or authorization as provided in these statutes.

x_____ _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

_____ _____
WITNESS DATE

PURPOSE OF DISCLOSURE:

☐ Changing Physicians ☐ Second Opinion ☐ At My (Patient) Request ☐ Insurance
☐ Continuing Care ☐ Legal ☐ Workers' Compensation ☐ School
Other: _____

1. I understand that this authorization will expire 180 days after the date appearing above. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying YUHS in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to his authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
4. I understand that I am being requested to disclose this information by Yale University Health Services for the following purpose:
   ☐ Continuity of Care
   ☐ Receiving communications about products or services I may wish to purchase.
5. My health care and payment for my health care will not be affected if I do not sign this form.
6. I understand I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it.
7. I understand that in compliance with CT general statute, I will pay a fee of $0.65 per page after the first 20 pages.
8. Patient over 18 must sign their own release.

_____ _____ OR _____ _____
SIGNATURE OF PATIENT DATE PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

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