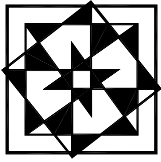

Hartford Gyn Center

Carol Watson M.D.
One Main Street, Suite N1
Hartford, CT 06106
Tel: (860) 525-1900
Fax: (860) 522-9913

Patient Name: ____

Date of Birth : ___________________________________ **Social Security #:** _______________________________________

I, ____ **authorize Hartford Gyn Center to:**

DISCLOSE TO / RECEIVE FROM ___________________________________ **Tel:** _________________________________
(Please circle one)

___________________________________ **Fax:** _________________________________
Street

____
City State Zip

The following information: ____

For the purpose of: ___ **Medical** ___ **Legal** ___ **Disability** ___ **Transfer** ___ **Insurance** ___**Other** _______________________

This authorization will be in effect for one year from the signed date below.
The patient has the right to revoke this authorization in writing at any time within the one year period.
The patient has the right to inspect the information that will be disclosed by this authorization.
The patient understands that a refusal to sign this authorization will not affect the patient's right to be treated by Hartford Gyn Center.
If the patient is a minor (under 18 years old), the patient's parents or legal guardian must sign this authorization. Minors requiring treatment for reproductive health or drug abuse may sign their own authorization.
The information disclosed under this authorization falls under applicable laws and may be subject to further disclosure by the recipient. Thus the information disclosed may be no longer protected by federal privacy regulations.

NOTICE TO INDIVIDUAL REQUESTING THE DISCLOSURE

Your signature below indicates that you understand that if the organization authorized to receive the information is not a health care provider or health plan and the information disclosed is NOT protected by the Title 42 CFR Part 2 and C.G.S.CH. 368x, then the released information may no longer be protected by the HIPAA Federal Privacy Regulation.

Signature: ____ **Date:** ______________________________
(Patient Signature or person granting authorization on behalf of patient. Parent or guardian if patient is under 18 years of age.)

Witness: ____

HIV RELATED INFORMATION

State Law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.
Signature: ____ Date: ______________________________

DRUG AND/OR ALCOHOL

This authorization may be revoked by me at any time, except to the extent that action has been taken in reliance thereon. This authorization, unless expressly revoked earlier in twelve months from the date signed . (PL93-282)
Signature: ____ Date: ______________________________

PSYCHIATRIC

The confidentiality of a psychiatric record is required under Connecticut General Statute. This information shall not be transmitted to anyone else without written consent or other authorization as provided in CGS. This authorization may be revoked by me at any time, except to the extent that action has been taken in reliance thereon. This authorization , unless expressly revoked earlier, expired in twelve months from the date signed.
Signature: ____ Date: ______________________________