AUTHORIZATION TO RELEASE INFORMATION
To Mansfield Family Practice

Patient Name Date of Birth Soc. Sec. #

Patient Address: Phone #

TO: Name		
Address		
Address		
City	State	Zip

From: Mansfield Family Practice, LLC, 34 Professional Park Road, Storrs, CT 06268, Phone: 860-487-0002, Fax: 860-487-4525

"I hereby authorize this practice to make the use and disclosures of my protected health information as indicated below".

******************All Sections Below must be Completed for Processing******************

Description of information to be disclosed (Describe what is to be disclosed, be specific.):

Description of the reason or purpose of this use or disclosure:

This disclosure is being made to: Dr. _____
Mansfield Family Practice, LLC
34 Professional Park Road
Storrs, CT 06268

Expiration Date: From (date) ____/_____/_____ To ____/____/____
OR Expiration Event:

The following information needs a separate consent to be Used or Disclosed. Please indicate your authorization by checking each item.

☐Consent to ☐Refuse Mental health records
☐Consent to ☐Refuse Communicable diseases (including HIV and AIDS)
☐Consent to ☐Refuse Alcohol/drug abuse treatment
☐Consent to ☐Refuse Other (please specify): _____

I understand that I may cancel this Authorization at any time, in writing. If the practice has already used this Authorization or if this Authorization was used so that I could obtain insurance coverage, I may be unable to cancel the Authorization. I understand that the practice will not condition treatment or payment based upon my signing this Authorization. I am signing this Authorization freely. No one has forced me to sign this Authorization. I understand that the information disclosed could be redisclosed by the recipient, and then it is no longer protected by federal regulations. I understand that if the information disclosed is related to HIV/AIDS and/or alcohol/substance abuse that the recipient may not redisclose it under Connecticut State Law. I have reviewed this authorization. I understand it. A copy has been provided to me.

Date: **Patient signature:**_____