MANSFIELD
F·A·M·I·L·Y
PRACTICE
A LIMITED LIABILITY COMPANY
34 PROFESSIONAL PARK ROAD
STORRS, CONNECTICUT 06268
TEL: (VOICE) 860/487-0002
(FAX): 860/429-1663

Authorization for Use or Disclosure of Specific Protected Health Information

Patient Name: _____ Patient Date of Birth: _____

I authorize disclosure of information regarding the patient's condition, treatment and prognosis to the following individual(s) or organization(s):

_____
_____

This medical information may be used by the persons or organizations I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization shall be in force and effect until nine (9) months after my death or _____
at which time this authorization expires. (date or event)

Authorization for release of PHI covering the period of health care (check one)

- ☐ from (date) _____- to (date)_____ OR
- ☐ All past, present and future periods.

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

- ☐Consent to ☐Refuse Immunizations
- ☐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 Medical Services
- ☐Consent to ☐Refuse Other (please specify): _____

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I acknowledge I am signing this Authorization freely, and no one has coerced or pressured me to sign the Authorization.

_____ _____
Signature Date

_____ _____
Print Name Phone Number