

Comprehensive Psychiatric Care, P.C.

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As required by the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and Connecticut law, this practice may not use or disclose your individually identifiable health information without your authorization except as provided in our Notice of Privacy Practices. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purpose of disclosure.

I hereby authorize you to use or disclose the specific information described below, only for the purpose and parties also described below.

I hereby authorize _____ to use or disclose health information concerning _____ as follows:
(NAME & ADDRESS OF PATIENT)

Description of health information to be used or disclosed *(If this is an authorization for the use or disclosure of psychotherapy notes, it may not be combined with an authorization for the use and disclosure of any other type of health information except other psychotherapy notes):*

I understand that this health information may include HIV-related information and/ or information relating to diagnosis or treatment of psychiatric disabilities and/ or substance abuse and that by signing this for, I am authorizing such information be disclosed.

This health information may be used or disclosed by:

_____ (name and address of person/entity to use and/ or disclose the health information)

This health information may be disclosed to and used by:

_____ (name and address of person/entity to receive and use the health information)

The information may be used and disclosed only for the following purposed (if you do not want to explain the purpose, write "At the request of the Individual":

This authorization shall remain in effect from the date signed below until 90 days post termination unless a specific date is listed _____.

(Expiration date of Authorization)

I understand that:

- ❖ I may inspect or copy the protected health information to be used or disclosed
- ❖ I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer.
- ❖ Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by HIPPA.
- ❖ I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).

If this box is checked, I understand that you will receive compensation from a third party for the use or disclosure of my information.

Patient Name: _____ Patient Signature: _____

Date: _____

Relationship to Patient (if signed by personal representative of Patient) _____

Date: _____

M.S. OKASHA, M.D., F.A.P.A., MEDICAL DIRECTOR