

Authorization for Release of Protected Health Information (PHI)

Optum Behavioral Care of Connecticut, P.C., on behalf of itself and affiliated companies, will use this form to obtain your written consent to disclose your PHI to the recipient of your choice. This request does not allow the recipient to make any of your treatment or direct care decisions. Please complete this form to consent to the release of your PHI, to the designated individual or organization, named in Section 2 below. When filling out this form, provide your most current information.

1. Patient Information (please provide current information)

Last Name		First Name	Middle Initial
Mailing Street Address			Apt. #
City	State		Zip
Date of Birth (mm / dd / yyyy)		Phone Number with Area Code	

2. Individual or Organization Authorized to Receive Information

I authorize Optum Behavioral Care of Connecticut, P.C., to disclose my PHI to the individual or organization designated below. I understand that there are certain parties that must protect the privacy of my PHI. These are health care providers and other parties who are required to do so under federal or related state laws. If my designated individual is not a health care provider or another party required to protect my PHI, it could be discussed and/or released by them without my permission.

Individual/Organization Name		Relationship to Patient	
Mailing Street Address			Unit/Suite #
City	State		Zip
Phone Number with Area Code		Fax Number with Area Code	

3. Purpose and Delivery Method of Disclosure

I authorize the above-mentioned facility to release my information for the following reason(s):

- Coordination of Care
- Insurance
- Legal
- Personal Use
- Other _____

I authorize the above-mentioned facility to release my information via the following delivery method (please select one):

- Pick-up In Person
- USPS Mail
- Fax
- Secure Email (provide email address below)

Email Address: _____

3. Description of Information to be Disclosed

I authorize the following records to be disclosed:

ALL Mental/Behavioral Health Records
(does not include psychotherapy notes)

If not **ALL**, please select one (or more) of the following record types:

- | | |
|--|---|
| <input type="checkbox"/> Attendance | <input type="checkbox"/> Medications/Dosing |
| <input type="checkbox"/> Assessments | <input type="checkbox"/> Provider Orders |
| <input type="checkbox"/> Billing Record | <input type="checkbox"/> Toxicology Results |
| <input type="checkbox"/> Consultations | <input type="checkbox"/> Treatment Plan |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Lab Results | |

The following items require special consent by law.
Check the boxes below to indicate your intent to include:

- Alcohol or Substance Use
- Genetic Information
- HIV/AIDS
- Reproductive Health Care Services

Please indicate in the space below the date(s) of service, for the above selected records, that you would like released (If this section is left blank, all dates of service for the above selected records will be included):

4. Expiration and Revocation

I understand that this consent will expire thirty-six (36) months from the date of my signature as noted below unless I revoke in writing, request a different date, or am a resident of a state that requires a shorter timeframe.

I wish for my consent to expire on a different date, noted here: _____

For those residing in the states below, the expiration date cannot exceed:

12 Months: MD, MN 24 Months: MT, VA, Puerto Rico 30 Months: ME

I further understand that I may revoke this authorization at any time by notifying, in writing, the facility where this authorization is being signed. I also understand the revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any releases made prior to the receipt of the written revocation.

5. Signature(s)

A. **Patient:** I have read and understand the above information. I acknowledge that by signing this form, I understand that my decision of whether or not to sign this form will not affect my eligibility for treatment or payment and am voluntarily giving consent to above-mentioned facility to disclose my PHI to the individual or organization designated in Section 2.

Signature of Patient

Date

B. **Personal or Legal Representative of Patient:** I have read and understand the request and acknowledge that by signing this form I have the legal authority to act on behalf of the patient, and I am attaching the appropriate supporting documentation to this request.

Printed Name of Representative

Relationship to Patient

Signature of Representative

Date

Please Return this Completed Form via Fax to:

Fax: Optum Behavioral Care of Connecticut, P.C.
833-449-5103
Please

keep a copy of this form for your records.