AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name: _____ Date of Birth: _____

I, the undersigned client, hereby authorize Heidi D. Hughart, LPC, MS, NCC, to use my Protected Health Information for the purposes described below, and/or to obtain Protected Health Information from or release Protected Health Information to the following (list by name):

Agency/Facility: _____

Contact Name: _____

Address: _____

Phone: _____

The nature and extent of Protected Health Information to be used or disclosed:

_____ Date of admission and discharge

_____ Diagnosis

_____ Discharge/Transfer Information

_____ Drug/Alcohol related information

_____ Employment

_____ Lab Results

_____ Legal/Court

_____ Medical/Physical Exams

_____ Info Relevant to HIV Status

_____ Psychiatric/Psychological Assessment

_____ Public Assistance/Entitlements

_____ Treatment notes

_____ Attendance, Scheduling

_____ Other information, specifically:_____

_____ **Limitations on disclosure:**_____

This Authorization and any information released under it are to be used for the specific purpose(s) of:

_____

_____

I understand that my Protected Health Information may include alcohol and/or drug treatment records protected by federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, medical information protected under the federal privacy rules of the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), 45 C.F.R. Parts 160 & 164, and HIV-related and psychiatric information protected under Chapters 368x and 899 of the Connecticut General Statutes, and that by signing this Authorization I am agreeing to its use or disclosure. I also understand that I may revoke this Authorization at any time by notifying Heidi D. Hughart, in writing, except to the extent that action has been taken in reliance on it.

This Authorization, if not revoked, will expire:

☐ Ninety (90) days after I have completed my evaluation and/or treatment

if less than 12 months from date signed – OR --

☐ Other: _____

(Specification of the date, event or condition upon which this authorization expires)

_____ _____

Client Signature/Legal Guardian Date

_____ _____

Clinician Signature Date

Heidi D. Hughart, LPC, MS, NCC
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203-415-8495