

**EASTERN REHABILITATION NETWORK**  
181 Patricia M. Genova Drive - Newington, CT 06111  
Tel: 860-667-5440

**PROVIDER AUTHORIZATION/RELEASE FOR USE/DISCLOSURE  
OF PROTECTED HEALTH INFORMATION TO OUTSIDE PARTIES**

Patient Name \_\_\_\_\_  
Address \_\_\_\_\_  
DOB \_\_\_\_\_

Subject to the statements below, I, the undersigned patient, hereby authorize Eastern Rehabilitation Network (ERN) to use my medical information, including, if applicable, protected drug and/or alcohol abuse, confidential HIV-related and psychiatric information ("Protected Health Information") for the purposes described below, and to obtain Protected Health Information from or release Protected Health Information to the following:

Name/Facility: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone (if known): \_\_\_\_\_

The nature and extent of Protected Health Information to be used or disclosed: *[Check applicable information]*

- Medical/Clinical Information  
 Billing Records  
 Other \_\_\_\_\_  
 Restrictions on Disclosure- must be documented on Patient Information/Disclosure Restriction Form \_\_\_\_\_

This authorization and any information released under it are to be used for the following purpose(s) *[please describe purpose for which release authorized, such as legal proceedings, medical care, insurance, etc.]*

I agree that a copy of this authorization will be as valid as the original. This authorization will be valid for a period of one year from the date below. I understand that I may revoke this authorization at any time by notifying the Patient Service Representative of Provider in writing, but if I do it won't have any effect on actions Provider took before it received the revocation.

I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations.

I understand that my treatment or continued treatment by Provider is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it.

\_\_\_\_\_  
Patient Signature (or authorized representative)      \_\_\_\_\_      Expiration Date \_\_\_\_\_  
Print Name: \_\_\_\_\_      Date

**\*\*Note**, if you are signing as the legally authorized representative of the patient, please indicate your relationship to the patient here (this should demonstrate your authority to consent to health care for the patient):

- Parent     Guardian     Conservator     Executor of the Estate     Power of Attorney

HIV RELATED INFORMATION

In the event that information released constitutes confidential HIV related information protected under Connecticut Law: This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

PSYCHIATRIC INFORMATION

If the event that information released constitutes confidential psychiatric information protected under Connecticut Law: This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it or of using it for any purpose other than that indicated above without the specific written consent by the person to whom it pertains, or as otherwise permitted by said law.

DRUG AND ALCOHOL ABUSE RECORDS

In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records Regulations: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.