NATHANIEL WITHERELL
Town of Greenwich Connecticut

70 Parsonage Road, Greenwich CT 06830

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I, the undersigned patient or legal representative, hereby authorize **Nathaniel Witherell** to disclose or obtain health information, *including if applicable*, information relating to the diagnosis or treatment of mental illness, drug and/or alcohol abuse and confidential HIV related information regarding:

Resident Name:_____ **Birth date:** ____/____/____ **Phone:** _____

Information may be ☐ Disclosed to
☐ Obtained from Other Facility

Name/Facility:

_____

Mailing Address:

_____

City/State/Zip _____

Phone #: (_____)_____

☐ Mail ☐ Fax to: _____
Fax to Healthcare Facilities/Providers only

2. The purpose of this disclosure or use is for the following reason:

☐ Medical ☐ Legal ☐ Disability ☐ Insurance

☐ At the request of the patient or legal representative

☐ Other (please specify) _____

3. The dates of service to be used or disclosed :

Date(s) of Service:

_____

4. Requested Information:

☐ **Complete Record** ☐ **Abstract Only** (See below)

Please specify if you need specific reports only:

☐ History & Physical ☐Laboratory Report
☐ Discharge Summary ☐ X-Ray Report
☐ Care Plans ☐ Physician Notes
☐ Consultations ☐ Nurses Notes
☐ Therapy Eval/Notes
☐ Medications List
☐ Other (please specify) _____

_____

I understand that my treatment or continued treatment by Nathaniel Witherell is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it. 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 I may inspect or request a copy of the information to be used or disclosed by the recipient.

This authorization will be valid for a period of one year from the signature date below. Medical records will only be released for dates of service which occur prior to the authorization date unless disclosure of a future service date is specifically authorized. I understand that I may cancel this authorization at any time by notifying Nathaniel Witherell in writing, but if I do it will not have any effect on actions that the release took before it received the cancellation.

Copy Fees: I understand that Nathaniel Witherell may charge a fee for copying and first class postage to the individual receiving the requested information. Copy fees will be applied in accordance with Connecticut Statute at $0.65 cents per page and $6.50 for an electronic copy.

_____ _____ _____
Signature of Resident or Legal Representative **Date** **Printed Name**

If not resident, state the relationship to resident/patient below (legal documentation required as applicable):

☐ Health Care Agent ☐ Conservator ☐ Executor of Estate ☐ Power of Attorney ☐ Other: _____

NOTE: The confidentiality of psychiatric, alcohol, drug and HIV related records is required by Connecticut General Statutes and/or Federal Regulations 42 CFR, part 2. This information shall not be re-disclosed to anyone else without written consent or other authorization as provided in the Connecticut General Statutes and/or Federal Regulation 42 CFR, part 2. A general authorization for the release of medical information is not sufficient for this purpose.