Shared Response Health Systems, LLC Authorization for Release/Disclosure of Information

Patie	ent Name:	Date of Birth:	SSN	Į:
Addı	ress:	City:	State:	Zip:
Tele	phoneEmail:			
I hei	reby authorize Shared Response Health Systems, LL	C to release/disclose in	formation to:	
Nam	ne/Entity:			
Address:C		City:	State:	Zip:
Fax:	Email:			
PUR	RPOSE OF DISCLOSURE:			
□ A 1	t Patient's Request			
□ O ₁	ther (please specify)			
INF	ORMATION TO BE RELEASED AS FOLLOWS:			
Tran	sporting Provider/Servicing Agency:			
☐ Inspection Only		Dates of Service:		
$\hfill\Box$ Copy of all medical records, including reports and bills		Dates of Service:		
□С	opy of other medical or billing information as specified:			
		Dates of Service:		
1.	I understand that this authorization will expire one year after I have signed this form, or other time frame as specified:			
2.	writing, and such revocation will be effective on the date Shared Response Health Systems, LLC receives written notice except to the extent that action has already been taken in reliance upon this authorization.			
3.	3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by privacy regulations.			
4.	I understand that I am not required to sign this form in	n order to receive treatm	ent.	
5. 6.	 5. I understand that there may be a fee for a copy of my medical record. 6. I understand that information to be released may include mental health information in accordance with C.G.S. § 52- 			
0.	146d, substance abuse information in accordance with with C.G.S. § 19a-581 et seq., except as indicated:	42 CFR 2, and/or HIV	AIDS-related infor	mation in accordance
Sign	ature of Patient:		Dat	e:
Pare	ent/Legal Guardian/Authorized Person:		Da	te:
Prin	t Name:	Relationship to Pati	ent:	
4			.1 •	10 11 000

A copy of the patient's and/or signee's government-issued identification must accompany this request. If applicable, proof of appointment of Power of Attorney or Conservator must be submitted.

NOTE TO RECIPIENT OF INFORMATION: Confidentiality of psychiatric, drug and/or alcohol abuse, and HIV/AIDS related records is required and no information from these specific records shall be transmitted to anyone else without written consent or authorization as provided under Connecticut General Statutes Chapters 899 and 368x and Federal Regulations 42 CFR 2. These laws prohibit you from making any further disclosure without specific written consent of the person to whom it pertains. A general authorization for the release of information is NOT sufficient for this purpose.