StayWell Health Center
Growing a healthier community one person at a time.

AUTHORIZATION TO OBTAIN AND DISCLOSE HEALTH INFORMATION

I _____, _____, _____ **authorize**
PLEASE PRINT – Name of Patient **Date of Birth** **Phone Number**

☐ **StayWell – Phoenix**
80 Phoenix Avenue
Waterbury, CT 06702
P: 203-756-8021
F: 203-465-5222

☐ **StayWell SE**
1302 South Main Street
Waterbury, CT, 06706
P:203-756-8021
F: 203-597-8190

☐ **StayWell – SE II**
1309 South Main Street
Waterbury, CT, 06706
P: 203-756-8021
F: 203-597-8637

☐ **StayWell Health Center**
30 Church Street
Naugatuck, CT 06770
P: 203-805-4929
F: 203-805-4928

☐ **StayWell – Driggs SBHC**
77 Woodlawn Terrace
Waterbury, CT 06710
P:203-596-9503
F: 203-596-9618

☐ **StayWell SBHC Wallace/Crosby**
3465 E. Main St/Pierpont Rd
Waterbury, CT 06705
P: 203-805-4916
F: 877-999-6308

☐ **StayWell SBHC Wilby/NE**
534 Bucks Hill Road
Waterbury, CT 06704
P: 203-805-4923
F: 203-805-5102

☐ **StayWell PIC/OASIS Program**
402 East Main St.
Waterbury, CT 06705
P:203-755-1143
F: 203-755-6006

❑ To **RELEASE** the following information to:

_____
PLEASE PRINT – Name of Medical Facility or Agency

_____
Address

_____

❑ To **OBTAIN** the following information from:

_____
Please print – Name of Medical Facility or Agency

_____
Address

_____

Dates of Service: _____

Information to be disclosed/obtained:

- ❑ Discharge Summary
- ❑ Consult reports
- ❑ History & Physical Examination
- ❑ Emergency Room Record
- ❑ Pap Smears
- ❑ Mammograms
- ❑ Colonoscopy Report
- ❑ Dental records & X-Rays
- ❑ Radiology Films / Reports
- ❑ Psych.
- ❑ Drug/Alcohol
- ❑ HIV
- ❑ Laboratory Tests
- ❑ Ob/Gyn
- ❑ Entire Record (*Consideration will be given to releasing the entire record ONLY when subsections of the record will not serve the intended purpose of the disclosure*)
- ❑ Immunizations
- ❑ Other: _____

This information will be released for the following purpose (**any other use is prohibited**)

❑ Disability ❑ Legal ❑ Moving out of state ❑ Specialist Care ❑To obtain Social Security Card
❑ Personal ❑ Transferring to New PCP ❑ Other: _____

- I understand that the records to be released may contain information pertaining to HIV-related, psychiatrics, drugs and or alcohol abuse treatment, and may contain other confidential information. I understand that the confidentiality of such records is protected under State and Federal Law and cannot be disclosed without my authorization unless otherwise provided by law.
- I understand that refusal to grant consent to release information will not jeopardize the patient's right to obtain present to future treatment, except where disclosure is necessary for the treatment.
- I also understand this consent is subject to revocation at any time by signing the "**CANCELLATION/REVOCATION**" section below, except to the extent that action has been taken in reliance thereon. Federal Law provides that once a release is signed for a Probation or Parole it may not be revoked. Federal law may subject to re-disclosure by the recipient and no longer protect the information disclosed by this institution. 42 CFR part 2 prohibits unauthorized disclosure of these records.
- This Authorization shall expire in 180 days after the date appearing below or 180 days after patient's final treatment.

Date: _____ **Signature:** _____ **Relationship:**_____
Patient/Client or Authorized legal representative/Guardian

Date: _____ **Signature:** _____ **Relationship:**_____
Witness

CANCELATION/REVOCATION:_____ (Signature of Patient/Client/Authorized Legal Representative)

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 state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.