Authorization for Disclosure of Health Information From The Treehouse Center for Children and Families, LLC

Phone: 860-684-5015 Fax: 860-684-3749

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and Connecticut law, this practice may not use or disclose your individually identifiable health information without your authorization except as provided in our Notice of Privacy Practices. Your completion of this form indicates that you are giving permission for the uses and disclosure described below.

Growth curves Office visits Lab data Consult notes Hospital records Immunizations for (child's name)	I hereby authorifollowing health		ter for Children and Fa	amilies, LLC to disclose the
In the form of: Flash Drive (\$10) Paper/Mail (45¢ per page) Fax (Free)* I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am authorizing such information to be disclosed. Effect of refusal to sign this authorization I understand that my refusal to sign this authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment. I understand that I may revoke this authorization at any time by notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt. I understand that if the recipient of the information is not a health care provider or health plan covered by the Federal Privacy Rule, the information used or disclosed as described may be redisclosed by the recipient and may be no longer protected the the Privacy Rule. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV-or AIDS-related information, and psychiatric/mental health information. I understand that I have the right to receive a copy of this authorization. Signature Phone Phone	J	☐ Growth curves	_	_
I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am authorizing such information to be disclosed. Effect of refusal to sign this authorization I understand that my refusal to sign this authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment. I understand that I may revoke this authorization at any time by notifying this medical practice in writing. My revoke this authorization at any time by notifying this medical practice in writing. My revoke this authorization is not a health care provider or health plan covered by the Federal Privacy Rule, the information used or disclosed as described may be redisclosed by the recipient and may be no longer protected the the Privacy Rule. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV-or AIDS-related information, and psychiatric/mental health information. I understand that I have the right to receive a copy of this authorization. Signature	for (child's name)to be sent to:			DOB:
I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am authorizing such information to be disclosed. Effect of refusal to sign this authorization • I understand that my refusal to sign this authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment. • I understand that I may revoke this authorization at any time by notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt. • I understand that if the recipient of the information is not a health care provider or health plan covered by the Federal Privacy Rule, the information used or disclosed as described may be redisclosed by the recipient and may be no longer protected the the Privacy Rule. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV-or AIDS-related information, and psychiatric/mental health information. I understand that I have the right to receive a copy of this authorization. Signature				
diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am authorizing such information to be disclosed. Effect of refusal to sign this authorization I understand that my refusal to sign this authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment. I understand that I may revoke this authorization at any time by notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt. I understand that if the recipient of the information is not a health care provider or health plan covered by the Federal Privacy Rule, the information used or disclosed as described may be redisclosed by the recipient and may be no longer protected the the Privacy Rule. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV-or AIDS-related information, and psychiatric/mental health information. I understand that I have the right to receive a copy of this authorization. Signature	In the form of: [Flash Drive (\$10)	☐ Paper/Mail (45¢ per	page)
 I understand that my refusal to sign this authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment. I understand that I may revoke this authorization at any time by notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt. I understand that if the recipient of the information is not a health care provider or health plan covered by the Federal Privacy Rule, the information used or disclosed as described may be redisclosed by the recipient and may be no longer protected the the Privacy Rule. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV-or AIDS-related information, and psychiatric/mental health information. I understand that I have the right to receive a copy of this authorization. Signature	diagnosis or treatm	nent of psychiatric disabilitie	s and/or substance abuse	
Signature Date Name Phone	 I understand to present or fut information is I understand to practice in writes receipt. I understand to covered by the redisclosed by other state or information, and information, and information, and information, and information, and information, and information. 	that my refusal to sign this ure treatment for psychial necessary for the treatment of the that I may revoke this autiting. My revocation will not that if the recipient of the e Federal Privacy Rule, to the recipient and may be federal law may prohibit uch as substance abuse and psychiatric/mental here.	s authorization will not jetric disabilities except whent. chorization at any time by ot affect actions taken by information is not a healthe information used or doe no longer protected the trecipient from disclostreatment information.	nere disclosure of the notifying this medical this medical practice prior to the care provider or health plantisclosed as described may be the Privacy Rule. However, sing specially protected IV-or AIDS-related
Name Phone				
	· ·			
			Pn	one

^{*}Please note: Most offices will not accept large documents by fax. Please inquire before choosing this option.