SAINT FRANCIS
Hospital and Medical Center

Mount Sinai
Rehabilitation Hospital
a SAINT FRANCIS *Care* Provider

Patient Label

COMMUNITY CARE TEAM AUTHORIZATION TO OBTAIN / RELEASE MEDICAL INFORMATION

Section 1: Who may discuss or disclose my confidential medical information?

I hereby authorize Saint Francis Hospital and Medical Center, 114 Woodland Street, Hartford, Connecticut, 06105, to discuss and/or disclose information from my medical records as described below.

Section 2: Who may receive my confidential medical information?

I authorize Saint Francis Hospital and Medical Center as part of its participation in the Community Care Team (CCT) to discuss and/ or disclose my confidential medical information with or to the following individuals or organizations that are members of CCT:

Advanced Behavioral Health, Inc.
Beacon Health Options
Blue Hills Hospital
Catholic Charities/Institute for Hispanic Families (IHF)
Capitol Region Mental Health Center
Department of Mental Health & Addition Services (DMHAS)
Charter Oak Health Center
City of Hartford Department of Health & Human Services
Community Health Network of Connecticut, Inc.
Community Health Resources
Community Health Services
Community Renewal Team
Community Substance Abuse Centers
Connecticut Community for Addiction Recovery (CCAR)
Harriott Home Health Services
Hartford Hospital
Hartford Dispensary
Hispanic Health Council
InterCommunity, Inc.
New England Home ~~Health Services~~ Care
Saint Francis Behavioral Health Group, P.C.
Saint Francis HealthCare Partners
Saint Francis Hospital & Medical Center
U.S. Department of Veteran Affairs
Wheeler Clinic
AIDS CT
Chrysalis Center, Incorporated
City of Hartford Department of Public Health
Community Partners in Action
Community Solutions
Hands on Hartford
ImmaCare Inc.
Interval House
Journey Home, Inc.
Malta House of Care
Mercy Housing and Shelter Corporation
My Sisters' Place
Salvation Army
South Park Inn, Inc.
Tabor House
The First Church of Christ in Hartford
The House of Bread, Inc.
The Open Hearth
YWCA Hartford Region

Other Agencies (Listed Below)

_____

Section 3: What information may be discussed and/or disclosed?

I authorize the following information to be discussed and/or disclosed:

Any and all medical information with respect to the treatment at Saint Francis Hospital and Medical Center of the patient named below, including information relating to diagnosis or treatment of mental health or drug or alcohol abuse and/or confidential HIV related information.

Section 4: What will my confidential medical information be used for?

I understand that the purpose of disclosing my confidential medical information is to help Saint Francis coordinate with other CCT members my health care, housing, care management and other needs, including the development of treatment plans, coordinating medical appointments, obtaining prescription medications, and other necessary services to ensure my health and wellbeing.

Patient Label

SAINT FRANCIS Hospital and Medical Center

Mount Sinai Rehabilitation Hospital
a SAINT FRANCIS Care Provider

COMMUNITY CARE TEAM AUTHORIZATION TO OBTAIN / RELEASE MEDICAL INFORMATION

Section 5. Other Important Information

I understand that Saint Francis Hospital and Medical Center may not condition my treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I understand I have the right to revoke this authorization at any time by notifying Saint Francis Hospital and Medical Center in writing at the address above. I understand the revocation will not apply to information that has already been released in reliance on this authorization.

I understand any discussion or disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected under state or federal confidentiality rules. **I also understand that if the Protected Health Information that is disclosed under this Authorization is confidential HIV/AIDS related information or alcohol or drug abuse related information, the recipient may not re-disclose that information under Connecticut State Law.**

A photocopy of this original shall be valid as the original.

This authorization shall be valid until _____.
If I do not specify an expiration date, event or condition above, this authorization shall expire 180 days from the date of signature.

Name of Patient: _____ (please print) Date: _____

Name of Authorized Representative: _____ Relationship to Patient: _____

Signature of Patient or Authorized Representative: _____

NOTICE

Psychiatric Records and Communications

In the event that information released constitutes privileged psychiatrist-patient communications:

"The confidentiality of this record is required under chapter 899 of Connecticut General Statutes. This material shall not be transmitted to anyone without the written consent or other authorization as provided in the aforementioned statutes." (§ 52-146i)

Drugs 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 part2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly 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." (42 C.F.R. § 2.32)

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 law. A general authorization for the release of medical or other information is NOT sufficient for this purpose." Conn. Gen. Stat. 19a-585(a)

Hartford Hospital
A Hartford HealthCare Partner

6816

Hartford Hospital/Institute of Living
Community Care Team
Authorization to Disclose Medical Information

Section 1: Who may release my confidential medical information?

I hereby authorize Hartford Hospital/The Institute of Living, 200 Retreat Avenue, Hartford CT 06106 (HH/IOL) as part of its participation in the Community Care Team (CCT), to release my medical record information as described below.

Section 2: Who may receive my confidential medical information?

I authorize Hartford Hospital/The Institute of Living to disclose my confidential medical information to the following individuals or organizations that are members of CCT:

Advanced Behavioral Health, Inc.
Blue Hills Hospital
Capitol Region Mental Health Center
Catholic Charities/Institute for Hispanic Families (IHF)
Charter Oak Health Center (FQHC)
City of Hartford Department of Health & Human Services
Community Health Network of Connecticut, Inc.
Community Health Resources
Community Health Services
Community Renewal Team
Community Substance Abuse Centers
Connecticut Community for Addiction Recovery
Department of Mental Health & Addiction Services (DMHAS)
Harriott Home Health Services
Hartford Behavioral Health
Hartford Dispensary
Hartford Healthcare, Inc. (Including the Institute of Living)
Hispanic Health Council
InterCommunity, Inc.
New England Home Care
Saint Francis Behavioral Health Group, P.C.
Saint Francis HealthCare Partners
St. Francis Hospital & Medical Center
U.S. Department of Veteran Affairs
Value Options/Beacon Health Option
Wheeler Clinic

Additional Rotating CCT Participants

AIDS CT
Chrysalis Center, Incorporated
City of Hartford Department of Public Health
Community Partners in Action
Community Solutions
Hands on Hartford
ImmaCare Inc.
Interval House
Journey Home, Inc.
Malta House of Care
Mercy Housing and Shelter Corporation
My Sisters' Place
Salvation Army
South Park Inn, Inc.
Tabor House
The First Church of Christ in Hartford
The House of Bread, Inc.
The Open Hearth
YWCA Hartford Region
Other Agency_____

Hartford Hospital
A Hartford HealthCare Partner

6816

Section 3: What information may be disclosed?

I authorize the following information to be disclosed to the individuals/organizations identified in Section 2 above:

My Entire Medical Record (including mental health, HIV, and or substance abuse records)

Section 4: What will my confidential medical information be used for?

I understand that the purpose of disclosing my confidential medical information is to help Hartford Hospital/The Institute of Living coordinate with other CCT participants my health care, housing, care management and other needs, including the development of treatment plans, coordinating medical appointments, obtaining prescription medications, and other necessary services to ensure my health and wellbeing.

Section 5. Other Important Information

I understand that HH/IOL may not condition my treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I understand I have the right to revoke this authorization at any time by notifying HH/IOL in writing at the address above. I understand the revocation will not apply to information that has already been released in reliance on this authorization.

I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the disclosed information may not be protected by state or federal law. **I also understand that if the medical information that is disclosed under this Authorization is confidential HIV/AIDS related information or alcohol or drug abuse related information, the recipient may re-disclose that information only as permitted or required by state or federal law.**

A photocopy of this original shall be valid as the original.

This authorization shall be valid until _____.
If I do not specify an expiration date, event or condition above, this authorization shall expire 180 days from the date of signature.

Name of Patient: _____(please print)
Date:_____Time:_____

Name of Authorized Representative: _____(please print)
Date:_____Time:_____

Signature of Patient or Authorized Representative:_____
Date:_____Time:_____

If signed by the individual's personal representative, describe the legal authority of the representative to act on behalf of the individual:_____
Date:_____Time:_____

Legal authority of representative verified by: _____