



Jewish Family Services of Greenwich

1 Holly Hill Lane, Greenwich, CT 06830 • (203) 622-1881

MEDICAL RECORDS RELEASE OF INFORMATION AUTHORIZATION

Client or Parent Name: _____ Date of Birth: _____

Client's Name.: _____ Telephone No.: (Home) _____
(If Patient is under 18) (Business) _____

I authorize the release of my medical records from: _____

I authorize the release of my medical records to: _____

AUTHORIZATION:

I hereby authorize the individual/entity listed above to release my own or my child's records described above, including AIDS/HIV, psychiatric, drug abuse and/or alcohol related information if applicable and use of the information for the purpose of:

At the request of the client

Other: _____

I understand that if the recipient of the information is not an entity covered by the federal Privacy Rule, the information used or disclosed as described above, may be re disclosed by the recipient and is no longer protected by 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/AIDS related information and psychiatric/mental health information. I have been informed that my refusal to grant consent to release of information relating to psychiatric treatment will not jeopardize my right to obtain present or future psychiatric treatment except where disclosure of the communication and records is necessary for treatment.

I understand that I am not required to sign this Authorization as a condition of treatment, payment, enrollment or eligibility for benefits.

I understand that I may revoke this authorization in writing at any time, except to the extent that the above institution has already taken action in reliance on the authorization. Unless I revoke this authorization prior to such time, this authorization shall expire on 12 months from the date of signature. By signing below, I acknowledge that I have read and understand this Authorization form.

X _____

SIGNATURE of Client or Client's Authorized Representative

TODAY'S DATE

AUTHORIZED REPRESENTATIVE (please print name) Relationship to Client/Authority to Act on Client's behalf.

If the client is a minor (under 18) or has a legal guardian, in most cases, this authorization must be signed by the client's parent or legal guardian.