GENERATIONS FAMILY HEALTH CENTER, INC.
CONSENT FOR DISCLOSING/RECEIVING HEALTH INFORMATION

PLEASE PRINT CLEARLY

PATIENT NAME:	PROVIDER NAME:		
PARENT/GUARDIAN NAME:	PATIENT#	DOB:	AGE of PATIENT:

CHOOSE ONE OF THE FOLLOWING: Are you giving us permission to RECEIVE or GIVE your protected health information?

I HEREBY AUTHORIZE GENERATIONS FAMILY HEALTH CENTER, INC. TO **RECEIVE INFORMATION FROM**:	I HEREBY AUTHORIZE GENERATIONS FAMILY HEALTH CENTER, INC. TO **GIVE INFORMATION TO**: (PERSON OR AGENCY, ADDRESS,CITY,ZIP)
NAME:	NAME:
ADDRESS	ADDRESS
CITY/ZIP	CITY/ZIP
PHONE/FAX:	PHONE/FAX:

MEDICAL RECORDS	*Initials*	DENTAL RECORDS	*Initials*	BEHAVIORAL HEALTH RECORDS	*Initials*
Entire Medical Record		Entire Dental Record		Entire Behavioral Health Record	
Only notes from specific dates (see below)		Only notes from specific dates (see below)		Only notes from specific dates (see below)	
Immunizations only		X-ray films		Psychiatric Medication Evaluation	
Lab or Diagnostic Imaging results		Billing		Initial Clinical Assessment	
Billing				Psychotherapy Notes	
Non-GFHC Records				Treatment Plan	
Physical exam only				Discharge Summary	
Other:		Other:		Billing	
				Other:	

Specific Dates of Treatment or Records Requested for Release: _____

PURPOSE OF RELEASE OF RECORDS: ***(Choose one)***						
	Personal Use		DSS		Attorney	
	Transfer of Care		Social Security Admin		Workman's Comp	
	Another Current Provider of Care		Other:		DCF	

I authorize Generations Family Health Center, Inc. to release/obtain all pertinent information regarding my treatment which may include information relating to medical, psychiatric, alcohol, and drug abuse, HIV/ AIDS, Sickle cell, to such facilities as is necessary for my treatment and care. I authorize Generations Family Health Center, Inc. to release/obtain all pertinent information regarding my treatment, including information relating to treatment for healthcare, psychiatric, alcohol and drug abuse, HIV/ AIDS, Sickle cell to any third party pay or for the purpose of security payments for services to the physician or organization furnishing the service. This facility, its employees, officers and attending physician are released from legal responsibly or liability for the release of the above information to the extent indicated and authorized therein.

I understand that my alcohol and/or drug treatment records are protected under State and Federal Confidentiality Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (see 42 USC290DD-2 for Federal laws and 42 C.F.R. Part 2 for Federal regulations, and Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time, except to the extent that action has been taken in reliance upon it.

I understand that I may revoke this authorization at any time, except where information has already been released pursuant to my authorization, provided that any such revocation is done in writing. I understand that the information released here may be subject to re-disclosure by the recipient and may no longer be protected by the Health Center's privacy practices or applicable privacy law. I understand that Generations Family Health Center, Inc. may not condition my treatment on my provision of this authorization.

This authorization will automatically expire in ***three hundred sixty-five (365) days*** from the date below. (P.A.89 246 and 52-146)

Signature of Patient (over age 18) Date Signature of Witness Date

Signature of Parent, Guardian, or Legal Representative (if under 18) Relationship Date

Mail/Fax to Generations Family Health Center, Inc. Location checked below:

☐ **WILLIMANTIC, CT 06226**
40 Mansfield Ave.
Fax: (860450-7396
Phone: (860)450-7471

☐ **DANIELSON, CT 06239**
42 Reynolds St.
Fax: (860)779-2191
Phone: (860)774-7501

☐ **NORWICH, CT 06360**
330 Washington St,
Ste. 510
Fax: (860)859-1278
Phone: (860)885-1308

☑ **PUTNAM, CT 06260**
202 Pomfret St.
Fax: (860)963-0015
Phone: (860)963-7917
& Across the Smiles

☐ **PUTNAM, CT 06260 – SBHC**
35 Wicker St.
Fax: (860)963-0015
Phone: (860)928-4699