COMMUNITY
HEALTH NETWORK
of Connecticut

MEMBER AUTHORIZATION TO SHARE HEALTH INFORMATION

Please sign this form in order for Community Health Network Of Connecticut (CHNCT) to share **protected health information** *(information that CHNCT has in its records about your health condition or treatment or payment for health care services)*, if the use or **disclosure** *(a release of information outside of CHNCT)* is not directly related to running the HUSKY programs or required by law or court order. It is your choice of whether or not you sign this authorization. You may choose not to sign it.

Member Name: **ID Number**:

I understand that if I sign this, I will allow Community Health Network of Connecticut (CHNCT) to use and share certain health information about me that they have.

I authorize _____at CHNCT to share personal health information with (name and address):_____

_____

_____

For the following reason(s):

_____

_____

_____

Type of Information CHNCT is Authorized to Share:

□ Medical □ Alcohol and/or Drug Treatment Records * □ HIV Related Information **

□ Eligibility or **Personal Information** *(For example, name, social security number, date of birth)*

□ Other_____

I accept the following statements:

1. I understand that my refusal to sign will not affect my ability to obtain services or benefits from the HUSKY program.
2. I understand that I may cancel this **authorization** (*a written form signed by you that gives CHNCT permission to use or share your health information for the reasons listed on the form*) at any time by notifying CHNCT in writing that I want to cancel. If I do tell CHNCT in writing that I want to cancel this authorization, this will not affect any actions taken by CHNCT before I asked for it to be cancelled. My **notification** (*notice informing CHNCT of something)* must be sent to: CHNCT, Attn: **Compliance Officer**, 290 Pratt Street, Meriden, CT 06450. The Compliance Officer makes sure CHNCT understands and follows certain laws.
3. I understand that the person who receives the information listed above must agree not to further share this information, although CHNCT cannot **guarantee** *(promise)* such confidentiality.
4. This authorization ends on _____(date) or upon _____(event). (If the use or disclosure is for research purposes, you can write "end of research study" or "none.")

_____ _____ _____

Signature of Member or Member's Representative | Member ID Number | Date

_____ _____

Printed Name of Person Who Signed | If Representative, Relationship to Member

***Alcohol and/or Drug Treatment Records:** This information has been disclosed to you from records protected by Federal confidentiality rule (42 CFR Part 2). The Federal Rules **prohibit** *(stop)* you from making any further disclosure of this information unless further disclosure is expressly permitted by written **consent** (*your permission*) of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT **sufficient** *(satisfactory*) for this purpose. The Federal Rules **restrict** *(place limits on)* any use of the information to investigate criminal activity or **prosecute** (*bring to court and take legal action against*) any alcohol or drug abuse patient.

****HIV Related Information:** 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.