SOUND COMMUNITY SERVICES, INC.
Authorization for Release of Information

Name: _____ D.O.B.:____/____/_____ SSN:_____

I understand that the information to be exchanged may contain protected substance abuse, psychiatric, and confidential HIV-related information (Protected Health Information).
I authorize Sound Community Services, Inc. to:

☐ ***Release*** Protected Health Information to: *and/or* ☐ ***Obtain*** Protected Health Information from:

_____
Individual / Organization Name, Address

The Protected Health Information that may be used or disclosed includes: [Check all that apply]

☐ Complete Medical Record
☐ Admission Assessment
☐ Progress Notes
☐ Discharge Summary
☐ Other (specify):_____
☐ Mental Health Information
☐ Drug/Alcohol related information
☐ HIV/AIDS related information
☐ Medications

Approximate Episode of Care Dates:
☐ All Episodes
☐ Specific: _____

The information released under this authorization will be used for the following purposes:
[Check all that apply]

☐ Assess for Intake Purposes
☐ Coordinate Care
☐ Provide Treatment
☐ Refer for Services
☐ Review History
☐ Other:_____

I understand this information will be used to provide comprehensive and coordinated services. I agree that a copy of this authorization will be as valid as the original. I understand this consent will expire as designated below, but in no case will it expire later than one year from the date of my signature. I give this consent freely and voluntarily and understand that refusal to grant authorization will not prevent me from utilizing services upon acceptance to Sound Community Services, Inc.

I understand that I may revoke this consent at any time prior to the release of the above information by making the request in writing to Sound Community Services, Inc. as indicated below, but that any such revocation will not apply to information already released. I understand that information, once disclosed to others, may be re-disclosed to entities not subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and therefore, may no longer be protected by HIPAA.

The confidentiality of this record is required under chapter 899 of the Connecticut General Statutes as well as Title 42 of the Untied States Code. This material cannot be transmitted to anyone without your written authorization, as provided for in these statutes and described in detail in the Sound Community Services Privacy Notification.

_____ _____
Signature of person served (or authorized representative) Date Staff Signature Date

**Note: If you are signing as the legal representative of the person served, please indicate your relationship: (This should demonstrate your authority to consent to health care for the person served)*

_____

Expiration Date ***(Note: Release expires 1 year after the date signed by the person served unless otherwise noted here.)***

I, _____ have decided to withdraw my authorization for Sound Community Services, Inc. to obtain or disclose protected health information to the above person, provider, or agency.

_____ _____
Signature of person served (or authorized representative) Date Staff Signature Date