Maine & Weinstein Specialty Group, LLC

Authorization of Release of Health Records

Patient name: _____ (Here in called the "Patient")

Party to whom records are to be sent: _____ ("Recipient")

_____ (Address)

I , _____, hereby authorize Maine & Weinstein Specialty Group, LLC to release to Recipient named above, Patient's medical and mental health records including a copy of Patient's complete and entire mental and physical health record, all records for Patient's care and treatment, including psychiatric and drug information, and information regarding HIV/AIDS status, treatment or testing, emergency room records, nursing notes, laboratory results (individually copied), all consent forms, and a copy of the bill for services rendered.

If any of the information to be released constitutes a mental health communication or a communication with a psychologist or psychiatrist, this release will serve as Patient's written release of that information. Patient understands that Patient may refuse to grant the consent for this release of psychiatric/psychological information, and that such a refusal will in no way jeopardize Patient's right to continue to obtain treatment, unless disclosure is otherwise permitted by law or necessary for treatment.

If any of the information to be released relates to treatment for alcohol or drug abuse, Patient understands that there are special requirements for Patient's consent to release as found in Part 2 of Title 42 of the C.F.R., which prohibits the future release of that information without Patient's consent, as referenced in the federal regulations, or as otherwise permitted by law.

TO THE RECIPIENTS OF THESE MATERIALS:

In the event that any of the disclosed information includes HIV/AIDSs information, this is protected under state law as follows:

> "This information has been disclosed to you from records whose confidentiality is protected by 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 said law. A general authorization from the release of medical or other information is NOT sufficient for this purpose." Any oral disclosure shall be accompanied or followed by the above notice. See Connecticut General Statute section 19a-585.

MENTAL HEALTH COMMUNICATIONS: If the released material contains confidential mental health communication, as designated in C.G.S. sections 52-146c through 52-146l, inclusive, please not the following:

> "The confidentiality of this record is required under Chapter 899 of the Connecticut general statutes. This material shall not be transmitted to anyone without written consent or authorization as provided in the aforementioned statutes." A copy of the consent form setting forth any limitations shall accompany the disclosure.

DRUG & ALCOHOL TREATMENT: No person, hospital, treatment facility or department of health may disclose the identity, diagnosis, prognosis or treatment of any patient in a treatment for drug and/or alcohol abuse that would be in violation of the federal state law. In the event that the records contain information regarding drug and/or alcohol abuse treatment, please note the following legal requirements and prohibitions:

> "This information disclosed to you is protected by state and federal law, specifically as outline in 42 C.F.R. Part 2. Federal law prohibits you from making further disclosure of this information unless the written consent of the person about whom the information pertains is obtained. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Federal law also restricts any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient." See Connecticut General Statute section 17-688.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclousure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

This authorization is valid for one year from the date of signing, unless and until it is revoked, in writing, and properly presented to the keeper of the records.

_____ _____

Signature of Patient
And his/her authorized representative,
Parent or guardian (if minor)

Date

Note: If Patient is a minor, or Patient has a duly authorized representative who is signing this Authorization, complete the following:

_____ (Print name of parent, guardian authorized representative)

_____ (Address)

_____ (Specify relationship to Patient)