MANSFIELD
F•A•M•I•L•Y
PRACTICE
A LIMITED LIABILITY COMPANY
34 PROFESSIONAL PARK ROAD
STORRS, CONNECTICUT 06268
TEL: (VOICE) 860/487-0002
(FAX): 860/429-1663

Authorization

Patient Name: _____ Date of Birth: _____

_____
Address City State Zip

_____ _____
Daytime Telephone Number Evening Telephone Number

_____ [Name of individual giving Authorization] hereby authorize Mansfield Family Practice, LLC to make uses and disclosures of my protected health information as follows:

1. Description of the Information to be Used or Disclosed.
[Please initial next to "All Records" if applicable. If the information is more specific, please describe in the space provided.]

All Records _____

_____

_____

1A. The following information needs a separate written consent to be Used or Disclosed. Please indicate your authorization by signing each item.

Psychiatric ☐Consent to ☐Refuse

Substance abuse ☐Consent to ☐Refuse

HIV ☐Consent to ☐Refuse

2. The Name or Specific Identification of Persons or Classes of Persons to Whom Disclosure May be Made.

_____
Name Phone number

_____
Address City State Zip

3. Description of the Purposes of the Requested Use or Disclosure. (Example: Insurance Change or Moving)

_____

_____
[Specifically describe the purpose of the requested use or disclosure. If the purpose is marketing and the covered entity is being compensated by a third party, the covered entity must disclose the amount of compensation.]

4. Expiration Date or Event.

This Authorization will expire on:

_____

[Describe the event or date. A statement such as "end of the research study" is sufficient if the use and disclosure of protected health information ("PHI") is for research. Otherwise, more specific language is required.]

5. Revocation.

I understand that I may revoke this Authorization at any time by providing written notice to Mansfield Family Practice, LLC. I understand that I may not be able to revoke this Authorization if Mansfield Family Practice, LLC has taken action in reliance on the Authorization, or if the Authorization was obtained as a condition of obtaining insurance coverage.

6. Services Not Conditioned on Authorization.

I understand that Mansfield Family Practice, LLC will not condition treatment, payment, enrollment or eligibility for benefits based on my signing this Authorization. I acknowledge that I am signing this Authorization freely, and no one has coerced or pressured me to sign the Authorization.

7. Redisclosure.

I understand that the protected health information disclosed under this Authorization may be subject to redisciosure by the recipient and no longer protected by the federal Privacy Regulations.

I also understand that if the **PHI** that is disclosed under this Authorization is confidential **HIV/AIDS** related information or alcohol or drug abuse related information, Mansfield Family Practice, LLC may not redisclose that information under Connecticut State Law.

8. Acknowledgement.

I acknowledge that I have carefully reviewed this Authorization and understand its provisions. If you would like to receive a copy of this executed agreement please enclose a self addressed stamped envelope.

_____ _____

Signature of Person giving Authorization Date

_____ _____

Name (Please Print) Relationship to Patient, if applicable