Benhaven

187 Half Mile Road North Haven, CT 06473 Tel: 203-234-8454 Fax: 203-234-8689

## Benhaven Children's Behavioral Services
## Authorization for Disclosure of Health Information

Patient Name: ______________________________________________________________

Date of Birth: __________________Phone:_____________Email:_________________________

Address:______________________________City:________________State:_____Zip:_________

1. *I authorize the use disclosure of the above named individuals heath information as described below.*

*To and from:*

Name:__________________ Address: ______________________ City: _______________ State: _____ Zip:_______

Phone: _____________________________ Fax:__________________________

*To and from:*

Name: Benhaven Inc. Address: 187 Half Mile Road City: North Haven State: CT Zip: 05473
Phone: 203-599.7704 Fax: 203-239.1318

The type and amount of information to be used or disclosed is as follows: (include dates if needed)

___Complete health records ___Assessment reports

___Complete educational records ___Consultation reports

___Observational summaries ___Data and/or graphs

___Other (please specify):______________________________________________________

2. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol or drug abuse.

3. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written and present my written revocation to Benhaven, Inc. I understand that the revocation will not apply to my insurance company when the law provides my insurer with right to contest a claim under our policy unless otherwise revoke, this authorization will expire on the following date, event, or condition: ___________________.

4. If I fail to specify and expiration date, event or condition, this authorization will expire in 365 days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect of copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information I can contact the Benhaven CBS Director at (203) 234-8454 Ext. 307.

__________________________________ __________
Signature of Patient or legal representative Date

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