THE TALCOTT CENTER FOR child DEVELOPMENT

230 Farmington Ave, Farmington, CT 06032 www.thetalcottcenter.com info@thetalcottcenter.com

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION.

I hereby authorize The Talcott Child Development Center to disclose/obtain information from the health records of:

Patient Name | Date of Birth | Phone number

Patient Address

Covering the period(s) of health care:

From (mmddyyyy) To (mmddyyyy)

I authorize the following information to be released by The Talcott Child Development Center.

- ☐ Doctor Orders
- ☐ Evaluations
- ☐ Progress Notes
- ☐ Therapist Notes
- ☐ Discharge Summary
- ☐ Other:

This information is to be disclosed to or obtained from:

Name of Individual/Organization	Address of Individual/Organization	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature of individual and date. 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 ensure treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carriers with it the potential for an unauthorized re-disclosure and may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Clinical Director at The Talcott Child Development Center.

_____ _____

Signature of Patient or Legal Representative | Date

If signed by legal representative:

_____ _____

Relationship to Patient | Signature of Witness

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