Giovanna M. Cammuso

AUTHORIZATION FOR RELEASE AND EXCHANGE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Connecticut and Federal law concerning the privacy of such information. I, the undersigned patient or legal representative hereby authorize Giovanna M. Cammuso, LCSW to use, disclose and/or exchange private health information including, if applicable, information relating to the diagnosis of mental illness, drug and/or alcohol abuse, and confidential HIV related information regarding:

Patient's Full Name:	**Date of Birth**
Parent / Legal Guardian / Conservator Name (If applicable)	**Patient / Guardian's Phone Number:**

- ✓ This authorization will be valid for a period of twelve months from the date of signature. I understand I may cancel this authorization at any time by notifying Giovanna M. Cammuso, LCSW in writing, but if I do it will not have any effect on actions that were taken before the cancellation was received.
- ✓ **I understand that my treatment or continued treatment by Giovanna M. Cammuso, LCSW is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it.**
- ✓ I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations.
- ✓ I understand that I may inspect or request a copy of the information to be used or disclosed.
- ✓ I understand that Giovanna M. Cammuso, LCSW and/or the Organization/Person I have listed above as the party to exchange information with may charge a fee for copying and postage related to the use/disclosure of my health information under this authorization. Any such fees are the sole responsibility of the patient or his/her representative.

Name of person or agency to exchange private health information with:	***Voice Number***	***Fax Number***

Street Address	***City***	***State***	***ZIP Code***

For Dates of Service: _____ to _____, Disclose the Following Private Health Information:

□ Discharge Summary □ Progress Notes □ Billing □ Psychological Reports □ Psychiatry Evaluations
□ Laboratory Results □ Neurology Reports □ Operative Reports □ Complete Record □ Other:

Purpose of Requested Use or Disclosure: Psychological Assessment & Therapy. Collaboration of care.

The confidentiality of psychiatric, alcohol, drug and HIV related records is required by Connecticut General Statutes and/or Federal Regulations 42 CFR, part 2. This information shall not be disclosed to anyone else without written consent or other authorization as provided on the Connecticut General Statues and/or Federal Regulation 42 CFR, part 2. A general authorization for the release of medical information is not sufficient for this purpose.

This authorization may be revoked by me at any time, except to the extent that action has been taken in reliance thereon. *This authorization expires twelve (12) months from the date signed, unless expressly revoked earlier.*

Signature of Patient or Representative	**Date of Signature**

If signed by someone other than patient, state your legal relationship to patient:

❑ Parent ❑ Guardian ❑ Conservator ❑ Executor of Estate ❑ Power of Attorney ❑ Other_____

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