AUTHORIZATION FOR RELEASE OF INFORMATION

Bryan C. Shelby MDJD LLC

215 Main St. Westport, CT 06880 P: (203)-221-0090 Fax (844)-530-1500

I, the undersigned patient or legal representative, hereby authorize Bryan C. Shelby MDJD to disclose and/or obtain health information, *including if applicable*, information relating to the diagnosis or treatment of mental illness, drug and/or alcohol abuse and confidential HIV related information regarding:

Patient or Evaluee Name:_____DOB:____/____/____

1. Name/Facility: _____

Address/Phone-Fax #/Email:_____

2. Requested Information or information to be disclosed:

_____

_____

3. The date(s) of service (if applicable):

_____

4. Purpose of disclosure: ☐ Treatment ☐ Legal ☐ Insurance ☐ Disability

☐ Other_____

I understand that my treatment or continued treatment by Bryan C. Shelby MDJD 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 by the recipient. **This authorization will be valid for a period of one year from the signature date below**. Medical records will only be released for dates of service which occur prior to the authorization date unless disclosure of a future service date is specifically authorized. I understand that I may cancel this authorization at any time by notifying Bryan C. Shelby MD JD in writing, but if I do it will not have any effect on actions that the releasee took before it received the cancellation.

_____ _____ _____

Signature (Patient /Legal Representative) **Date** **Printed Name**

(If this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2), the federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65.)