GILEAD
COMMUNITY SERVICES, INC.

P.O. Box 1000, 222 Main St. Extension, Middletown, CT 06457 • (860) 343-5300 • Fax (860) 343-5306

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client Name: _____ Date of Birth: _____
Address: _____

Subject to the statements printed on page two, I, the client named above, hereby authorize Gilead Community Services, Inc. to use my medical information, including, if applicable, protected drug &/or alcohol abuse, confidential HIV-related, & psychiatric information ("Protected Health Information") for the purposes described below, & to obtain Protected Health Information from or release Protected Health Information to the following:

Name/Agency: _____ Phone *(if known)*: _____
Address: _____
_____ Email *(optional)*: _____

The nature and extent of Protected Health Information to be used or disclosed
[Check Yes or No to indicate which of the following types of information may be used or disclosed. Each line item must have a Yes or a No checked.]:

Yes	No		Yes	No	
☐	☐	Discharge Summary / Information	☐	☐	Educational Information
☐	☐	Psychosocial Assessments / Information	☐	☐	Vocational Information
☐	☐	Psychiatric Summary / Information	☐	☐	Financial Information
☐	☐	Substance Abuse Summary / Information	☐	☐	Housing Information
☐	☐	Confidential HIV-related Information	☐	☐	Other: _____
☐	☐	Medical Information/Physical Exam	☐	☐	Limitations on Disclosure (if any):
☐	☐	Legal Information			_____

This authorization and any information released under it are to be used for the following purpose(s)
[Check all that apply, but at least one purpose must be checked.]:

☐ To provide ongoing treatment/rehabilitative/recovery services
☐ To coordinate service efforts with family/concerned persons/treatment providers
☐ Other: _____

I agree that a copy of this authorization will be as valid as the original. This authorization will be valid for a period of two years from the date below. I understand that this information may be used/disclosed on an ongoing basis and that it may include written, oral, or electronic information communicated by mail, phone, fax, email, or in-person communications. I understand that I may revoke this authorization at any time by notifying my Gilead Primary Plan Manager (who will document the revocation on this form), but if I do, it won't have any effect on actions Gilead Community Services, Inc. took before it received the revocation. 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 my treatment or continued treatment by Gilead Community Services, Inc. is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it.

Client Signature: _____ Date: _____
(If Client has a guardian/conservator of person, client signature indicates only that this authorization has been reviewed)

Conservator/Guardian Signature: _____ Date: _____
(If Applicable)

Primary Plan Manager to complete this area ONLY in the event this Authorization is revoked:
Date this Authorization was revoked: _____ Attested to by (signature): _____

Any information obtained or released by Gilead Community Services, Inc. to authorized persons is subject to the following notices:

Psychiatric Information:

In the event that information released constitutes confidential psychiatric information protected under Connecticut law:

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making further disclosure of it or of using it for any purpose other than that indicated above without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law.

Drug and Alcohol Abuse Information:

In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records regulations:

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 this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains 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. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

HIV-Related Information:

In the event that information released constitutes confidential HIV-related information protected under Connecticut law:

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.