Connecticut Medical Home Initiative (CMHI) for
Children and Youth with Special Health Care Needs (CYSHCN)*

Authorization for Release of Protected Health Information Form

I/We the undersigned hereby authorize all physicians, medical providers, medical facilities, therapists, schools, early intervention services, medical insurance companies, and any other health care professional or agency involved in my child's care to communicate with and/or release information, which may include information relating to medical, psychiatric, alcohol, and drug abuse, HIV/AIDS, Sickle Cell Disease, to any or all of the following:

Southwest Region, Stamford Health

ALL SECTIONS IN THIS FORM MUST BE COMPLETED AND SIGNED ON HIGHLGHTED AREAS

Child/Youth Name:	**DOB:**
Child/Youth - Race/Ethnicity:	**Primary Language:**
Parent/Guardian Name:	**Phone Number:**
Parent/Guardian Email:	

Has the child been to the dentist within the last year? ☐ **YES** ☐ **NO**

How long has the child been seeing this dentist? ☐ **LESS THAN ONE YEAR** ☐ **MORE THAN ONE YEAR**

Dentist Name: _____

Is the parent/guardian concerned about the child's weight? ☐ **YES** ☐ **NO**

Does the child/youth have an out of range BMI? ☐ **NO** ☐ **YES - HIGH** ☐ **YES - LOW** ☐ **UNKNOWN**

PLEASE SPECIFY THE TIME FRAME FOR THE INFORMATION YOU AUTHORIZE TO BE DISCLOSED:

☐ **All information maintained at any time by the discloser**

☐ **Information maintained by the discloser from:**

Month:	**Day:**	**Year:**

For the purpose of evaluation and/or care coordination:

The confidentiality of this record is required under Connecticut General Statutes 19a-25. The material shall not be transmitted to anyone without written consent or authorization as provided in the aforementioned statutes. If the patient is under 18 years of age, parent or legal guardian must sign.

I may revoke this authorization at any time, except to the extent action has been taken in reliance thereon. This authorization, unless expressly revoked earlier, **expires on one year from date signed**. I understand that the information released here may be subject to re-disclosure by the recipient and may no longer be protected by the above-named facilities' privacy practices or applicable privacy law.

Signature:	**Date:**

If signed by the patient's personal representative, describe the legal authority of the representative to act on behalf of the patient: _____

I acknowledge the offer and/or receipt of the Notice of Privacy Practices from all current providers of care. (HIPAA)

Signature:	**Date:**

*The CMHI for CYSHCN is a program supported by the State of CT Department of Public Health. Information is available on their website at www.ct.gov/dph/medicalhome . Revised 2023