CONSENT TO DISCLOSE SENSITIVE HEALTH INFORMATION FOR TREATMENT PURPOSES TO PCP, HOSPITAL OR SPECIALIST

Please complete, sign and return this form if you want your Primary Care Provider (PCP), hospital or specialist who manages your care to see sensitive electronic health information that HUSKY Health Program (HUSKY) has about you from other providers. Remember that your PCP, hospital or specialist will use this information about you for treatment and care management purposes **ONLY**.

1. MEMBER'S INFORMATION			
Last Name	First Name	Date of Birth (MM/DD/YYYY)	HUSKY ID #
Address Line 1	Address Line 2	City, State, Zip	
Phone Number	Email Address		

2. PROVIDER'S INFORMATION (to be completed in advance by PCP, hospital or specialist)			
Provider Name	Phone Number	Provider CMAP ID #	Provider's NPI #
Facility Name	Email Address	Facility CMAP ID #	Facility NPI #
Address Line 1	Address Line 2	City, State, Zip	

3. TYPE OF INFORMATION I want HUSKY to share information with my provider(s) about (check all that apply):		
☐ Behavioral Health*	☐ Alcohol and/or Drug Treatment Records**	☐ HIV Related Information***

4. EXPIRATION OF CONSENT Unless you revoke it sooner, this consent expires on:_______/_____/20___or upon ____________________________ (Event). If you don't fill in a date or event, this consent **automatically expires in 2 years**, unless revoked earlier.

5. SIGNATURE			
Signature of Member or Member's Representative	Printed Name of Person who Signed	If Representative, Relationship to Member	Date

Notes to Member:

- Refusing to sign this form will not prevent you from getting services or benefits from HUSKY.
- You may revoke this consent at any time by telling HUSKY in writing, unless we already shared information based on this form.
- After HUSKY gives information to your PCP, hospital or specialist, we cannot stop them from sharing that information with others, but they must follow laws on how they may use and share your health information.

Notes to Primary Care Provider:

*** Behavioral Health Records:** The confidentiality of psychiatric records is required under chapter 899 of the Connecticut general statutes. This material shall not be transmitted to anyone without written consent or other authorization as provided in the aforementioned statutes.

**** Alcohol and/or Drug Treatment Records:** This information has been disclosed to you from records protected by Federal confidentiality rule (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 patient.

***** HIV Related Information:** 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 state law. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose.

PROVIDERS: PLEASE SUBMIT COMPLETED FORMS TO: HUSKY Health Attention: **Compliance** Fax: 203.265.2780
Mail: P.O. Box 5005, Wallingford, CT 06492 • Questions, call: 1.800.859.9889