Celine M Paillot, Ph.D. **Psychological Services**

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Authorization to Release / Obtain Medical Records

Patient Name:

Date of Birth:

Address:

City: State:_ Zip:_ Phone:

I hereby authorize Celine Paillot Ph.D. to:

☐ **Release** Protected Health Information from my medical records to: ☐ **Obtain** Protected Health Information from my medical records from:

Name: Phone/Fax:

Address: City: State: Zip:

INFORMATION TO BE RELEASED OR ACCESSED IN EITHER VERBAL OR WRITTEN FORM

☐ All medical records including diagnostic evaluation, progress notes, phone calls, labs, consults

Purpose of Disclosure:

☐ Coordination of Care ☐ School / College ☐ Family Member Access to Treatment
☐ Consult/Second opinion ☐ FMLA / Disability ☐ Insurance application (e.g., long-term care)
☐ Transfer of Care ☐ Legal (Please specify): ☐ Other:

1. I understand that this authorization will expire one year after I have signed this form, or as specified here:
2. I understand that I may revoke this authorization at any time by notifying Celine Paillot Ph.D. or the other clinician or organizational provider in writing, and my revocation will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by privacy regulations.
4. I understand that I am not required to sign this form in order to receive treatment.
5. I understand that there may be a fee for a copy of my medical record.
6. I understand that information to be released or obtained may include mental health information in accordance with CGS 52-146(d), substance abuse treatment information in accordance with 42 CFR 2.1-2.67, and/or HIV/AIDS-related information in accordance with CGS 19a-585(a), except as indicated below.

☐ No Substance Abuse treatment should be disclosed ☐ No HIV/AIDS information should be disclosed

Signature of Patient Date

Print Name

Parent/Legal Guardian/Authorized Person Date

Please send to:

Celine Paillot Ph.D. 652 Boston Post Rd Suite 8 Guilford, Connecticut 06437, celine@drcelinepaillot.com