Form FLC7

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Upon presentation of the original or a photocopy of this signed authorization:

(1) Name and address of person giving permission to release information:

From: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

(2) Name and address of health provider or entity authorized to release this information:

To: _____

Address: _____

City: _____ State: _____ Zip Code: _____

(3) Statement of Authorization and Purpose:

I request that health information regarding my care and treatment be released to the CONNECTICUT BAR EXAMINING COMMITTEE, including its authorized staff, agents and representatives, 100 Washington Street, Hartford, CT 06106, which is conducting an investigation into my professional reputation and fitness for the practice of law as set forth on this form. In accordance with Connecticut State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

a. This authorization may include disclosure of information relating to ALCOHOL/ DRUG ABUSE, MENTAL HEALTH TREATMENT and CONFIDENTIAL HIV/AIDS RELATED INFORMATION only if I place my initials on the appropriate line in Item 4 (e). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 4 (e), I specifically authorize release of such information to the CONNECTICUT BAR EXAMINING COMMITTEE, including its authorized staff and agents.

b. If I am authorizing the release of ALCOHOL/DRUG ABUSE, MENTAL HEALTH TREATMENT and CONFIDENTIAL HIV/AIDS RELATED INFORMATION, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law.

c. I have the right to revoke this authorization at any time by writing to the health care provider listed in Item (2) above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

d. I understand that signing this authorization is voluntary, but failing to sign it, or revoking it before the CONNECTICUT BAR EXAMINING COMMITTEE, including its authorized staff

and agents, receives necessary information, may delay or prevent my admission to the bar. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure. I understand that I may inspect or have copies made of the information to be used or disclosed (EXCEPT PSYCHOTHERAPY NOTES).

e. Information disclosed under this authorization may be redisclosed by the recipient (except as noted above in Item (3)b), and this redisclosure may no longer be protected by federal or state law.

f. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICATION CARE WITH ANYONE OTHER THAN AN ATTORNEY FROM THE CONNECTICUT BAR EXAMINING COMMITTEE, including its authorized staff and agents.

g. My permission, unless expressly revoked earlier, automatically expires upon being admitted and sworn in as member of the Connecticut Bar.

(4) Specific Information to be Released:
Instructions: This form may not be used to release both psychotherapy notes and other types of health information. If this form is being used to authorize the release of psychotherapy notes, a separate Form 7 must be used to authorize the release of any other health information. Authorizations for use or disclosure of sensitive health information (such as alcohol/drug, HIV/AIDS or mental health) should be initialed in subsection (e) below.

□ (a) Entire Medical Record

□ (b) Only information related to:

(1) hospitalization for treatment of a mental, emotional, nervous or behavioral disorder or condition, OR

(2) treatment for schizophrenia or other psychotic disorder, bipolar or major depressive mood disorder; drug or alcohol abuse; impulse control disorder, including kleptomania, pyromania, explosive disorder, pathological or compulsive gambling; or paraphilia such as pedophilia, exhibitionism, or voyeurism.

□ (c) Only the period of events from (insert date) _____ to (insert date) _____.

□ (d) Psychotherapy notes **ONLY*** (by checking this box I am waiving any psychotherapist-patient privilege)

□ (e) I specifically authorize the release of the following sensitive information from my health record: (*Initial all that apply)*

_____ Alcohol/Drug Abuse Treatment

_____Confidential HIV/AIDS related Information

_____ Mental Health Information (other than psychotherapy notes)

*** PSYCHOTHERAPY NOTES means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are kept separate from the rest of the individual's medical record.**

(5) I hereby release, discharge and exonerate the Connecticut Bar Examining Committee, its staff, agents and representatives and the institution or treating professional named above so furnishing information from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records or other information or the investigation made by the Connecticut Bar Examining Committee.

_____
(Signature of applicant)

_____
(Date)

Subscribed and sworn to before

me this _____ day of

_____, 201__

_____
(Notary Public/Commissioner of the Superior Court)

Notice to Recipient of Information:

Federal and state law prohibit making any further disclosure of alcohol and/or drug abuse information (42 CFR Part 2), HIV-related information (Chapter 368x of the C.G.S.), psychiatric or other mental health information (Chapter 899 of the C.G.S.), without specific written authorization. If the disclosure contains information concerning HIV/AIDS related, alcohol or drug abuse information, the following notice applies:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2) or state law. The Federal rules or state law 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 said law. 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.