The Metropolitan District
water supply · environmental services · geographic information

AUTHORIZATION FOR DISCLOSURE/RELEASE AND VERBAL/ WRITTEN COMMUNICATION INVOLVING PROTECTED HEALTH INFORMATION

I understand that the records (conversations/written communications) to be released may contain information pertaining to Medical, Psychiatric, Drug and/or Alcohol Abuse Treatment, and/or Confidential HIV (AIDS) related information.

Patient Name:_____ Date of Birth: _____ Social Security #: _____

Address: _____

Medical Provider:_____

Address_____

ONGOING COMMUNICATION: I hereby authorize *reciprocal* ***VERBAL*** and ***WRITTEN*** *information exchange between:* The Medical Provider stated above and **The Metropolitan District, 555 Main Street, Hartford, CT 06103**.

RECORDS RELEASE: I hereby authorize the Medical Provider stated above to release records that may contain Protected Health Information to The Metropolitan District, 555 Main Street, Hartford, CT 06103.

DATES OF TREATMENT COVERED BY THIS RELEASE:
☐ All prior episodes of care ☐ Limited to the following date(s):_____

INFORMATION TO BE DISCLOSED/DISCUSSED:
☐ All Protected Health Information ☐ Other (*specify)*: _____

PURPOSE OF RELEASE- *Any other use is prohibited*
☐ Verification of Physician's Certification of Serious Illness in accordance with Conn. Gen. Stat. § 16-262d.

EXPIRATION OF AUTHORIZATION: This authorization if not cancelled, will expire: _____
(If blank, authorization will expire 12 months from date of signature)

I understand that refusal to grant permission will in no way affect my right to obtain present and future treatment, except where disclosure of such communication and records is necessary for treatment. I understand that I may revoke this authorization at any time (not retroactively), by signing the "Cancellation/Revocation" section below, except to the extent that action has been taken in reliance on it (i.e. probation, parole, etc.). **This authorization, if not revoked earlier by me, will expire when acted upon or in one year of signature.** I further understand that the Confidentiality of psychiatric, drug and/or alcohol abuse and HIV records are protected under State and Federal law and cannot be disclosed without my written authorization unless otherwise provided for by law. I understand that I may make a request to inspect and/or copy the information to be used and that the agency will provide me with a copy of this signed authorization. The information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by Federal law.

_____ _____
Signature of Patient or Legal Representative If Legal Representative, specify relationship
_____Patient is a minor, _____ years of age ____Patient unable to authorize because_____

Witness:_____ Date:_____

CANCELLATION/REVOCATION:
Patient/Legal Representative Signature: _____

****A PHOTOCOPY VERSION OF THIS FORM SHALL BE AS VALID AS THE ORIGINAL****

Please complete and return this form within seven days of receipt to:
The Metropolitan District c/o Credit & Collections● 555 Main Street ● Hartford, CT 06103
Telephone: (860) 278 7850 ● Fax (860) 560 4030

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PHYSICIAN'S CERTIFICATION OF SERIOUS ILLNESS

TO BE COMPLETED BY PHYSICIAN

The Metropolitan District (MDC) customer referenced below is seeking to prevent termination of his or her water service due to the fact that the customer, or someone within the household, is suffering from a serious illness or life threatening condition. In accordance with Conn. Gen. Stat. § 16-262d, the MDC will not terminate service to the customer's property, provided that a physician certifies in writing that the customer, or someone within the household, is suffering from a serious illness or a life threatening condition that would be detrimentally affected by the loss of water service. **After certification of a serious illness or life threatening condition, the customer is nonetheless still required to enter into a reasonable payment plan and pay all current charges for water use.**

Patient's Name: _____ Phone # _____

Property Address: _____ Account # _____

The above referenced patient is considered to be suffering from (check one):

☐ No serious illness or life threatening condition.

☐ A serious illness for which water is vital to the patient's condition for reasons other than taking medication.

☐ A life threatening condition that would endanger the life of the customer or a member of the customer's household if water service were terminated.

Description of illness and requirement for water:

_____

_____

_____

Please indicate the duration of any serious illness or life threatening condition identified above. Any duration over 1 year will require a new certification form to be completed after 1 year.

☐ 1 month or less ☐ 1-3 months ☐ 4-6 months ☐ 6-9 months ☐ 9-12 months

PHYSICIAN CERTIFICATION

I certify, under penalty of law pursuant to C.G.S. § 20-13c or as otherwise provided by law, that the information contained within this certification regarding my patient is true and accurate to the best of my knowledge.

Physician's Name: _____ Phone # _____

Fax # _____

Physician's Address:

_____ State License # _____

Physician Signature _____ Date _____

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