Medical Records Release/Request Form

Patient Authorization for Use or Disclosure of Protected Health Information: As required by the Health Portability and Accountability Act of 1996 (HIPAA) and CT Law, a practice may not use or disclose identifiable health information without your authorization except as provided in our Notice of Privacy Practices. Your completion of this form means that you give permission for uses and disclosure described below. Review and complete this form entirely. You may wish to ask the person or entity you want to receive your information to complete those sections detailing the information to be released, and the purposes for the disclosure. Per DPH Regulation 192.14.43, if you are leaving the practice, we have the right to dispose of your records once copies have been transferred.

I hereby authorize this medical practice_____
(name) (address)
to release health information on patient named below:

Patient Name (Print) _____ Date of Birth _____

Other name eg; (maiden) _____ Telephone _____

Address _____ City/ State _____ Zip _____

Date of Service Release _____ OR, the entire Medical Record ☐

Reason for release (must be noted): _____

Send medical records to: _____ Address _____

City _____ State _____ Zip _____ Phone ( ) _____ Fax ( ) _____

DATE NEEDED BY: _____Please note: We will do everything we can to accommodate urgent requests; if you have an appointment scheduled and need the records by that date, please tell us.

RESTRICTIONS: I understand the recipient of this information may not use or disclose this information except for the expressed purposes identified above; or such use or disclosure is specifically required or permitted by law.

I understand my medical record may include information relating to sexually transmitted disease; acquired immunodeficiency syndrome (AIDS); human immunodeficiency virus (HIV); behavioral/mental health services; and/or treatment for alcohol and/or drug abuse. I request the following exclusions as indicated by my initials:

EXCLUSION(S): Alcohol/Drug _____, Behavior/Mental Health/Psychiatric_____, Sexually Transmitted Disease _____,

HIV/AIDS _____, Other _____; specify other exclusion _____

I understand I have the right to request that services I have paid out-of-pocket, not be disclosed to my health plan.

This authorization is effective _____ through _____ (dates must be specified).

Signature: _____ Print Name: _____ Date: _____

If this form is completed by someone other than patient, please print name, address, and initial below to indicate relationship.

Name: _____ Address: _____

Guardian: _____ Conservator: _____ Parent: _____ Patient's Representative: _____

I understand that I have the right to receive a copy of this authorization.

Refusal to Sign Authorization: I understand that:

- By declining to sign this form my medical (health care) treatment and insurance benefits will not be affected, however, my medical records CANNOT be released.
- I may revoke this authorization at any time by notifying this medical practice in writing as described in the Notice of Privacy Practices. My revocation will not affect actions taken prior to its receipt.
- If the recipient of my information is not a health care provider/health plan covered by HIPAA, the information may be re-disclosed by the recipient and no longer is protected by HIPAA. However, other State or Federal laws may prohibit recipient from disclosing specially protected information, such as abuse treatment information, HIV/AIDS-related information or psychiatric/mental health information. As referenced in section 20c (b), CT Statutes, physicians may charge $.65 per page to copy medical records, plus any conveyance fees the office is required to pay. Fees are payable in advance, by cash or credit card.

Approved 6/09; Revised 11/11