Authorization for Access/Release of Information

NAME

_____

LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH:_____ _____ SS#:_____-____-_____ MEDICAL RECORD #:_____

MO DAY YR

ADDRESS:_____ CITY:_____ STATE: ___CT___ ZIP:_____

DAY PHONE:_____ EVENING PHONE: _____

I hereby authorize Health Assistance interVention Education Network for Connecticut Health Professionals and related entities to:

☐ release information from my record to: ☐ obtain information from:

NAME: _____ PHONE:_____ FAX: _____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

☐ **Inspection Only**

INFORMATION TO BE RELEASED OR OBTAINED (IN EITHER VERBAL OR WRITTEN FORM) as follows:

Dates of Service:

☐ **Copy of Standard Report (includes, as appropriate, discharge summaries, operative notes, results of X-ray and lab tests and history and physical.)**

☐ **Copy of other Medical or Billing Information as specified:**

PURPOSE OF DISCLOSURE:

☐ Changing physicians ☐ Consultation/second opinion ☐ Social Security
☐ School ☐ Insurance (other than payment) ☐ Continuing Care
☐ Other (please specify) ☐ At Patient's Request ☐ Legal (please specify)

1. I understand that this authorization will expire one year after I have signed the form, or other time frame as specified:
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it 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 redisclosure 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 or payment for my care.
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, substance abuse or HIV/AIDS-related information, pursuant to C.G.S. sections 52-146d through 52-146i, C.G.S. 19a-585 and C.G.S. 19a-126h, except as indicated below:

   ☐ No Mental Health ☐ No Substance Abuse ☐ No HIV/AIDS

_____

Signature of Patient/Participant Date **FOR OFFICE USE ONLY**

Print Name

_____

Parent/Legal Guardian/Authorized Person Date

Relationship to patient/participant

F4918 (N 0403) A COPY OF THIS FORM MAY BE RECEIVED AFTER SIGNING