RELEASE RECORDS FROM MEDICAL GROUP OFFICE

PATIENT INFORMATION

Name: _____

Parent's Name (if minor):_____

Telephone #: Home/Cell: _____

Email Address:_____

Date of Birth: _____

PRESENT ADDRESS OF PATIENT

_____
Street

_____
Town/City State Zip

INFORMATION REQUEST

A FEE MAY BE CHARGED FOR THIS SERVICE

I authorize the **NUVANCE HEALTH MEDICAL PRACTICE** to disclose the information described below to:

Name of Individual / Institution: _____

Address of Individual / Institution: _____

_____

Date(s) of Treatment: _____

Format: ☐ Paper ☐ CD ☐ Secure Online Portal - Email address required above

☐ Visit Notes ☐ Pathology Reports ☐ Imaging Reports

☐ Laboratory Reports ☐ Medication / Vaccines ☐ Procedure Reports

☐ Drug & Alcohol Abuse Records* Initial: _____

☐ Mental Health Records* Initial: _____

☐ HIV-AIDS Records* Initial: _____

☐ Other Information: _____

*** If checking the box for Drug & Alcohol Abuse Records, Mental Health Records or HIV/AIDS records, place initials where indicated that you specifically authorize release of these records.**

-Office Use Only-

Requester ID verified by:

_____
Employee Initials

Medical Record #:

_____

Date copies released/mailed:

_____

A copy of this signed authorization form must be given to the patient or patient's representative.

Date on which Authorization will expire: _____ / _____ / _____ If blank expiration is 12 months from date of signature

AUTHORIZATION

I hereby authorize that the records described above may be released by the NUVANCE HEALTH MEDICAL PRACTICE. I understand that, if the recipient of the information is not a health care provider or health plan covered by the federal Privacy Rule, the information used or disclosed as described above may be redisclosed by the recipient and is no longer protected by the Privacy Rule. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as genetic, substance abuse treatment information, HIV/AIDS-related information and psychiatric/mental health information. I have been informed that my refusal to grant consent to release of information relating to psychiatric treatment will not jeopardize my right to obtain present or future psychiatric treatment except where disclosure of the communication and records is necessary for treatment.

I understand that NUVANCE HEALTH MEDICAL PRACTICE may refuse to provide me with health care that is solely for the purpose of creating health information for disclosure to a third party if I refuse to sign this Authorization for the disclosure of health information to the third party.

I understand that I am not required to sign this Authorization as a condition of treatment, payment, enrollment or eligibility for benefits.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has already taken in reliance on the authorization. The revocation letter should be sent to Health Information Services Department of Danbury Hospital at the above address.
By signing below, I acknowledge that I have read and understand this Authorization form.

X _____ _____

SIGNATURE of Patient or Patient's Authorized Representative **TODAY'S DATE**

_____ _____

AUTHORIZED REPRESENTATIVE (please print name) **Relationship to Patient/Authority to Act on Patient's Behalf**

If signed by the Patient's Representative, specify the signer's relationship to the patient and describe relationship to patient and authority to act on their behalf. If the patient is a minor (under 18) or has a legal guardian, in most cases, this authorization must be signed by the patient's parent or legal guardian. If a minor patient is receiving treatment for psychiatric conditions, drug/alcohol abuse, venereal disease or HIV/AIDS, the minor's consent may be required for disclosure of the records. If NUVANCE HEALTH MEDICAL PRACTICE determines that the minor's consent is necessary to release the requested records, NUVANCE HEALTH MEDICAL PRACTICE will contact the minor to obtain his/her authorization.

D84352 Dev: 12/00 Rev: 7/05, 2/12, 11/13, 4/15, 11/16

NOTICE

PROHIBITIONS ON REDISCLOSURE

Psychiatric Records and Communications

In the event that the information released constitutes privileged psychiatrist-patient communications:

The confidentiality of this record is required under Chapter 899 of the Connecticut General Statutes. This material shall not be transmitted to anyone without written authorization as provided in the aforementioned statutes.

Drug and Alcohol Abuse Records

In the event that the information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records Regulations:

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

HIV Related Information

In the event that information released constitutes confidential HIV related information under Connecticut law:

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific 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.