AUTHORIZATION TO RELEASE OR OBTAIN HEALTH INFORMATION

Medical Records Department
575 Main Street
Middletown, CT 06457
Fax: 860-343-7379

Patient Name :____ Previous Name: ______________________________________

Date of Birth: ________/________/________ Phone #: (________)________-________

I AUTHORIZE CHC TO RELEASE MY INFO TO: **OR** **I AUTHORIZE CHC TO OBTAIN MY INFO FROM:**

I AUTHORIZE CHC TO RELEASE MY INFO TO:	I AUTHORIZE CHC TO OBTAIN MY INFO FROM:
Name:____	**Name**:____
Address (City/State/Zip Code):__________________________	**Address (City/State/Zip Code):**__________________________
____	____
____	____
Phone #: (______)_____-______ **Fax #:** (______)_____-______	**Phone #:** (______)_____-______ **Fax #:** (______)_____-______

If to **ME**, my records should be released via:

☐ Mail ☐ Fax (____) _____ - _______ ☐ Pick-Up ☐ E-Mail __________________________

All Medical Records requests must be processed by Medical Records Department

The type of information to be released or obtained is as follows (check the appropriate boxes and include other info where indicated):

☐ Progress Notes ☐ Dental records, including x-rays ☐ Immunizations

☐ Consultation Notes ☐ Labs ☐ X-ray, CT Scan, MRI, US results

☐ Complete health record (No telephone encounters) ☐ Complete health record (With telephone encounters)

☐ Other: ____

Date(s) of Service: ☐ From the dates _____________ to _______________ or ☐ From start of care to present

The Medical Records Department will release the last 3 YEARS worth of records unless a different time period is specified above.

*****If drug/alcohol abuse, psychiatric/mental health, or HIV/AIDS related information is to be included, you must check each box below.*****

☐ Drug/Alcohol Abuse* ☐ Psychiatric/Behavioral Health ☐ HIV/AIDS related information

*However, if you do not wish to disclose all of your drug/alcohol abuse information, please indicate what information to EXCLUDE here:

____

I AM SIGNING THIS AUTHORIZATION FOR THE FOLLOWING REASON:

☐ Legal ☐ Transferring Care ☐ Coordinating Care ☐ Relocation ☐ Other:____________________________________

This authorization will expire 90 days from the date on which it was signed, unless I indicate a different expiration event or date below:

____

I understand that I have a legal right to revoke this authorization at any time/ I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Community Health Center, Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to his authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

I understand authorizing the use or disclosure of the information identified is voluntary. I can refuse to sign this authorization. I need not sign this form to ensure healthcare treatment. I can contact the Privacy Officer if I have questions about my health information.

By signing below, I acknowledge that I have read and understand this authorization form and that CHC has 30 days to fulfill my request.

____ ____________________________
Signature of Patient or Legal Representative Date

____ ____________________________
Print Name Relationship to Patient