



## AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned patient or legal representative, hereby authorize **The Hospital of Central Connecticut** to disclose or obtain health information, *including if applicable*, information relating to the diagnosis or treatment of mental illness, drug and/or alcohol abuse and confidential HIV related information regarding:

**Patient Name:** \_\_\_\_\_ **Birthdate:** \_\_\_/\_\_\_/\_\_\_ **Phone:** \_\_\_\_\_

<p><b>Information may be</b> <input type="checkbox"/> <b>Disclosed to</b> <input type="checkbox"/> <b>Obtained from</b> <u>Other Facility</u></p> <p>Name/Facility: _____ Mailing Address: _____ City/State/Zip _____ Phone #: (_____) _____ [ ] Hand-Carry [ ] Fax to: _____</p>	<p><b>3. The dates of service and the type(s) of information to be used or disclosed is as follows:</b></p> <p><b>Date(s) of Service:</b> _____ <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Emergency Visit</p>
<p><b>2. The purpose of this disclosure or use is for the following reason:</b></p> <p><input type="checkbox"/> Medical <input type="checkbox"/> Legal <input type="checkbox"/> Disability <input type="checkbox"/> Insurance <input type="checkbox"/> At the request of the patient or legal representative <input type="checkbox"/> Other (please specify) _____</p>	<p><b>4. Requested Information:</b></p> <p><input type="checkbox"/> Complete Record <input type="checkbox"/> Abstract Only</p> <p>Please specify if you need specific reports only:</p> <p><input type="checkbox"/> History &amp; Physical <input type="checkbox"/> Laboratory Report <input type="checkbox"/> Discharge Summary <input type="checkbox"/> X-Ray Report <input type="checkbox"/> Operative Reports <input type="checkbox"/> EKG Report <input type="checkbox"/> Consultations <input type="checkbox"/> X-Ray Films (Radiology Dept) <input type="checkbox"/> Billing Statement (Patient Accounts Dept) <input type="checkbox"/> Other (please specify) _____</p>

I understand that my treatment or continued treatment by The Hospital of Central Connecticut is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it. I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations. I understand that I may inspect or request a copy of the information to be used or disclosed by the recipient.

**This authorization will be valid for a period of one year from the signature date below.** Medical records will only be released for dates of service which occur prior to the authorization date unless disclosure of a future service date is specifically authorized. I understand that I may cancel this authorization at any time by notifying the Health Information Management Department in writing, but if I do it will not have any effect on actions that the hospital took before it received the cancellation.

**Copy Fees:** I understand that The Hospital of Central Connecticut may charge a fee for copying and first class postage to the individual receiving the requested information. Copy fees will be applied in accordance with Connecticut Statute at \$0.65 cents per page.

\_\_\_\_\_  
**Signature of Patient or Legal Representative**                      **Date**                      **Printed Name**

*If not patient, state the relationship to patient below (legal documentation required as applicable):*

Parent  Guardian  Conservator  Executor of Estate  Power of Attorney  Other: \_\_\_\_\_

**NOTE: The confidentiality of psychiatric, alcohol, drug and HIV related records is required by Connecticut General Statutes and/or Federal Regulations 42 CFR, part 2. This information shall not be re-disclosed to anyone else without written consent or other authorization as provided in the Connecticut General Statutes and/or Federal Regulation 42 CFR, part 2. A general authorization for the release of medical information is not sufficient for this purpose.**

**For Hospital Use Only:** Completion Date: \_\_\_\_\_ Completed by: \_\_\_\_\_ MR# \_\_\_\_\_

Department:  HIM  RAD  BEH  EH  Physician Practice Other: \_\_\_\_\_