HIPAA AUTHORIZATION FOR RELEASE OF PATIENT RECORDS

Patient/Patients' Name: _____

I, _____, hereby authorize

(Name of Doctor)_____to release the medical health records:

(please check one)

☐ Copy of complete and entire medical record including all of our records for care and treatment, including psychiatric and drug information, and information regarding HIV/Aids status, treatment or testing, emergency room records, nursing notes, laboratory results (individually copied), pathology reports, x-ray reports, films, all consent forms, and a copy of the bill for services rendered.

. Immunization records only

. Other:_____

Please send to: **The Pediatric Center PC**
126 Morgan Street
Stamford, CT 06905

Pick up by:_____

Contact #:_____

If any of the information to be released constitutes a psychiatric communication or a communication with a psychologist, this release will serve as my written release of that information. I understand that I may refuse to grant the consent for this release of psychiatric/psychological information, and such a refusal will in no way jeopardize my right to continue to obtain treatment, unless disclosure is otherwise permitted by law or necessary for treatment. I understand that no psychotherapy notes my disclosed by my signing this authorization and that a separate authorization would be required for the release of psychotherapy notes.

If any of the information to be released relates to treatment for alcohol and drug abuse, I understand that there are special requirements for my consent to release as found in Part 2 of Title 42 of the C.F.R., which prohibits the further release of that information without my consent, as referenced in the federal regulations, or as otherwise permitted by law.
Reason for release of records:
_____
_____

This authorization is valid unless and until it is revoked, in writing, and properly presented to the records office of the provider listed above.
I understand that if the person or the entity that receives the information is not a health care provider or health plan covered by the federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.

I understand that I may revoke this authorization in writing at any time by submitting a written notice of my revocation, except to the extent that action has been taken in reliance on this authorization.

The authorization expires one year from the date of signing of this authorization _____ (insert date)

Certain information regarding substance abuse treatment and counseling and reproductive health services and counseling may be contained in the medical record of a minor. Under Connecticut State law, this information cannot be released, even to the parent, without the minor's consent. **Therefore, all patients 13 years or older must sign this authorization for release of information to anyone (including parent) other than another healthcare provider.**

*Signature of Patient (required if patient is 13 years or older):_____

Signature of Parent (or guardian or his/her authorized representative):_____

Relationship to patient: _____Date:_____

TO THE RECIPIENT OF THESE MATERIALS:
In the event that any of the disclosed information includes HIV/Aids information, this is protected under state law as follows:

> "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." Any oral disclosure shall accompany or be followed by the above notice. See Connecticut General Stature section 19a-585.

PSYCHIATRIC COMMUNICATIONS: If the released material contains confidential psychiatric communication, as designated in C.G.S. sections 52-146d through 52-146i, inclusive, please not the following:

> "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 consent or other authorization as provided in the aforementioned statutes." A copy of the consent form setting forth any limitations shall accompany the disclosure.

DRUG & ALCOHOL TREATMENT: No person, hospital, treatment facility or department of health my disclose or permit the disclosure of the identity, diagnosis, prognosis or treatment of any patient in a treatment for drug and\or alcohol abuse that would be in violation of federal or state law. In the event that the records contain information regarding drug and\or alcohol abuse treatment, please note the following legal requirements and prohibitions:

> "This information has been disclosed to you from records protected by federal and state confidentiality rules (2 C.F.R. 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." See Connecticut General Statute section 17a-688.

Signature:_____ Relationship to child/self: _____ Picked up by:_____

Date:_____