HAMDEN PEDIATRICS

HIPAA AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME: _____ **DOB**:_____

ADDRESS: _____

I, _____, the undersigned patient or legal representative, hereby authorize the practice to disclose or obtain health information, including a copy of my complete and entire medical record, any treatment or testing, emergency room records, nursing notes, laboratory results (individually copied), pathology reports, radiology reports, all consent forms, a copy of bills for services rendered, and including if applicable, information relating to the diagnosis or treatment of mental illness, drug, and/or alcohol abuse, and confidential HIV/AIDs status related information regarding the patient listed above.

Purpose of this disclosure is for the following reason:

- ▢ Changing Physicians (Physician's name: _____)
- ▢ Legal
- ▢ Disability
- ▢ Insurance
- ▢ At the request of the patient or legal representative
- ▢ Other: _____

Please note, Hamden Pediatrics will send free of charge, copies of: immunization history, most recent well care exam, growth charts, and allergy, medication, and problem lists. If any additional items are requested to be copied, $0.65 per page (allowable under Connecticare Statute) will be charged. By signing this form, I understand that there may be a fee for copying and the postage of additional health records.

Information to be released:

- ▢ Basic medical record (no charge)
- ▢ Complete medical record (additional charge may apply as noted above)
- ▢ Other: _____

Please send records: to/from (circle one)

Name/Facility:_____

Mailing Address: _____

City/State/Zip: _____

Phone: _____Fax: _____

Please send records by:

- ▢ Fax (to the fax number listed above)
- ▢ Mail (mail to the address listed above)

Please initial the following:

_____I understand that my family's treatment or continued treatment by Hamden Pediatrics, P.C. 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 this 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 Hamden Pediatrics, P.C. in writing, but if I do it will not have any effect on actions that the release took before it received the cancellation.

_____I understand that no psychotherapy notes may be disclosed by my signing of 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 Code of Federal Regulations, which prohibits the further release of that information without my consent, as referenced in the federal regulations, or as otherwise permitted by law.

_____ _____

Signature of Patient/Guardian/ Legal Representative Date

_____

Printed Name of Patient/Guardian/Legal Representative

_____

Relationship to Patient
(If a representative signs, describe the representative's authority to act on behalf of the person)

If any of the information to be released constitutes 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 the 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 treatment.

_____ _____

Patient/Guardian signature to authorize release of psychiatric/psychotherapy notes Date

Please see the following page of this form for special disclosure information regarding mental health, drug and/or alcohol abuse, and HIV-related information.

Special Disclosure Information

HIV/AIDS INFORMATION: 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 be accompanied or followed by the above notice. See Connecticut General Statute 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 note 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 may 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 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 (42 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.