Authorization to Disclose Medical Record Information

Please send completed form to:
ConnectCare and Wellness LLC. 33 Union City Road unit 1d, Prospect, CT 06712, USA

Patient Information

Patient's Name: _____

_____Patient's Address: _____

_____D.O.B: _____City:

_____State: _____Zip: _____Phone #: ( )

_____**Release Information**

I authorize ConnectCare and Wellness *to:* ☐**Send my medical records to:** ☐**Request my medical records from:**

Name/Facility: _____Attention:

_____Address: _____

_____Phone: _____City: _____State:

_____Zip: _____Fax: _____Purpose of Request:☐Personal☐Continued Care (Appt. with Specialist)☐Legal ☐Insurance

☐Transfer of care (New Physician) ☐Other:_____

Information to be Released

**Please specify date ranges.*

☐Abstract (*Generally recommended for transfer of care. It includes 2 years of notes and labs and 5years of diagnostics.)

☐Office Visits*_____to _____Specify Provider(s): _____

☐Lab Results:*_____to _____☐Radiology/Imaging Reports: *_____to _____

(If radiology **images**, please contact the radiology department directly:

☐Other *(please be specific)*:_____

Legally Protected Information

The following items will not be included, unless specifically authorized.

☐Genetic Testing Initial: _____

☐HIV/AIDS Results Initial: _____

☐Sexually Transmitted Diseases Initial:_____

☐Psychiatric Health (Include Behavioral Medicine Notes) Initial: _____

☐Substance Use Disorder Care *(42CFRPart2Records)* Initial:_____

☐Reproductive Health Care Services Initial: _____

Fees & Format

We may charge a fee for asking and sending copies (HIPAA 45CFR, 164.524). For many patients, an Abstract (2 years of notes and labs and 5 years of diagnostics) is enough for their care. For a complete record or more than 3 years of notes, the rate may go up due to cost. At no time will the cost-based fees exceed Connecticut law (Section 20-7c of the CT General Statutes).

Preferred format for release *(file size restrictions may apply)*

☐Paper ☐Fax ☐Patient Portal

I understand I can cancel this authorization at any time. I must give a written statement to ConnectCare and Wellness to cancel. Canceling won't affect information already shared with consent. I understand this authorization is good for 12 months, unless noted or canceled. Please note an expiration date if less than 12 months:___/___/___.

- *I understand that granting the release of this health information is not required. I do not need to sign this form to get care.*
- *I understand that my health record may have details on my mental health, substance abuse disorders or otherwise sensitive information.*

Releasing information may lead to unauthorized re-release. Which may not be protected by federal confidentiality rules.Signatures

Patient/Legal Representative* Signature:_____Date: _____

Print Name of Legal Representative:_____Relationship to Patient: _____

**You must show proof that you're an authorized representative with access to members'/patients' records. Include the signed authorization with this request.*

This authorization must be completed in its entirety or it will not be processed.