



PATIENT NAME: _____

DOB: _____

MRN: _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. I authorize ConnectCare & Wellness LLC. (CCWS) to obtain/release/exchange my health information specific to the following date or time period: _____ or All episodes of care

RECORDS FROM: ConnectCare & Wellness LLC. (CCWS)

2. OBTAIN FROM:

Provider: _____

Address: _____

Phone: _____

Fax: _____

RELEASE TO:

Address: _____

Phone: _____

Fax: _____

3. Patients may elect to have copies of their medical record provided electronically.

Please check to indicate your wish to have your medical records provided in an electronic format.

Email address: _____

4. Purpose for which disclosure is to be made: _____

5. Information to be disclosed/exchanged:

Discharge Summary
 History and Physical Exam
 Consultations
 Medications
 Other: _____

Operative Report
 Pathology
 Emergency Dept. Report
 Office Notes

Progress Notes
 Laboratory Report
 Radiology Report
 PRINT ELECTRONIC BOTH
EXAM: _____

I understand this may include health information relating to (check if applicable):

HIV (Human Immuno deficiency Virus) infection
 Treatment for alcohol and/or drug abuse

Behavioral Health
 Genetic Testing

6. I understand that if the person(s) or entity(s) that receives the information is not a health care provider or health plan covered by federal privacy regulation, the information described above may be re-disclosed and is no longer protected by those regulations. Therefore, I release CCWS, its employees and contractors from all liability arising from this disclosure of my health information. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

7. I understand that CCWS may receive compensation for the authorized use/disclosure of this information.

PLEASE CONTINUE TO PAGE 2 AND COMPLETE THE AUTHORIZATION.



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PAGE2: AUTHORIZATION

8. I understand that I may inspect or request copies of any information disclosed by this authorization. It is my understanding that this authorization will expire in 90 days from the date signed below. I understand that I may revoke this authorization by notifying, in writing, the department that provided the information, knowing that previously disclosed information would not be subject to my revoke request.
9. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.
10. I understand that this authorization shall be retained as part of my protected health information in accordance with applicable CCWS policy. I have received a copy of this authorization.
11. This authorization expires on _____ or ninety days from the date this authorization was signed. I further understand that I may revoke this authorization in writing at any time except to the extent that action has been taken on it.

Patient or Legal Representative: _____ Date: _____

Witness Signature: _____ Date: _____

Relationship to Patient if Signature Not Patient: _____

Photo ID verified By: _____ Receipt Date/Time _____ / _____

MAIL THE COMPLETED FORM TO:

ConnectCare and Wellness LLC.

33 Union city, Unit 1D Prospect CT 06712

860-200-8532.

<https://connectcareandwellness.com/>