Authorization for Access/Release of Information

_____ _____ _____ _____
FIRST NAME LAST NAME MI MAIDEN/OTHER

DATE OF BIRTH ____/____/____ HOME PHONE: _____ CELL PHONE: _____
MO DAY YR

I hereby authorize New England Integrated Primary Care fax number **203-467-1859** and related entities to:

□ Release information from my record to: _____

□ Obtain information from: _____

DOCTOR/FACILITY NAME: _____

ADDRESS: _____

Information to be released from Dates of Service: _____ to _____

□ Copy of Standard Report (includes, as appropriate, discharge summaries, operative notes, results of X-ray and lab tests and history and physical.)
□ Copy of other Medical or Billing Information as specified: _____
_____

I understand that information to be released or obtained may include mental health, substance abuse or HIV/AIDS-related information, pursuant to C.G.S. sections 52-146d through 52-146i, C.G.S. 19a-585 and C.G.S. 19a-126h. The confidentiality of this record is required under Chapter 899 of the Connecticut General Statutes as well as Title 42 of the United States code. This material shall not be transmitted to anyone without written consent or authorization as provided in these statutes.

By signing this form I am specifically authorize the release of information relating to:

☐Substance Abuse Treatment ☐HIV/AIDS related testing ☐Mental Health Information

Signature of Patient_____ Date_____

PURPOSE OF DISCLOSURE:

□ Changing physicians	□ Consultation/second opinion	□ Social Security
□ School	□ Insurance (other than payment)	□ Continuing Care
□ Other (please specify)	□ At Patient's Request	□ Legal (please specify)

1. I understand that this authorization will expire one year after I have signed the form, or other time frame as specified:
2. I understand that I may revoke this authorization at any time by notifying the providing organization, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by privacy regulations.
4. I understand that I am not required to sign this form in order to receive treatment or payment for my care.
5. I understand that there may be a fee for a copy of my medical record.
6. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
7. I understand that I will get a copy of this form after I sign it.

_____ _____ _____
Signature of Patient Print Name Date

_____ _____ _____
Parent/Legal Guardian/Authorized Person Relationship to patient Date