Middlesex Health — Authorization to Release or Obtain Information

CC4648

Patient Name: _____ DOB:_____/_____/_____

Patient's Address: _____
(Street) (City) (State) (Zip Code)

Patient's Telephone #: _____ Alternate Telephone Phone #: _____

I hereby authorize Middlesex Health to release/obtain all medical information with respect to the treatment of the above-referenced patient. Some highly sensitive medical conditions are listed below that require individual authorization, otherwise the information will not be released.

I authorize Middlesex Health to: ☐ Release my records to: OR ☐ Obtain my records from:

Name: _____ Phone No.: _____

Address: _____

City: _____ State: _____ Zip Code: _____

I authorize the following medical record documents to be released/obtained (check all that apply):

➡ **DATES OF SERVICE:** _____

☐ Abstract: (History and Physical Exam, Discharge Summary, Consult Report, Emergency Department Report, Operative/Procedure Report, Pathology Report, Lab Results, Radiology Report) ☐ Complete Medical Record

☐ Radiology Report ☐ Operative/Procedure Report ☐ Therapy Notes (PT/OT/Speech/Chemotherapy/Radiation Therapy)

☐ Pathology Report ☐ Emergency Room Record ☐ Discharge Summary ☐ Cardiology Tests ☐ Medication List

☐ Immunization Record ☐ Pulmonary Function Test ☐ Lab Results ☐ Family Medicine ☐ Multispecialty

☐ Surgical Alliance ☐ Care Coordination ☐ Middlesex Health - Primary Care

☐ Other- please specify: _____

Please check the clinical area that you are requesting medical records for:

☐ Inpatient ☐ Emergency ☐ Ambulatory Surgery ☐ Urgent Care ☐ Multispecialty ☐ Surgical Alliance

☐ MHPC (Indicate location): _____ ☐ Urology ☐ Family Medicine

☐ Crescent Street OB/GYN ☐ The Beit Paely Center for Mental Health ☐ Other:_____

If not requesting your own medical records, State and Federal law protect the categories of information listed below. Please indicate whether you want such information to be released/obtained, and if so, indicate the dates of service (or all dates) where appropriate. If this is left blank, such information will NOT be disclosed:

- Reproductive Health → Dates of Service: _____ ☐ YES ☐ NO Initials: _____
  *Reproductive Health Includes all medical, surgical, counseling or referral services relating to the human reproductive system, including, but not limited to, services relating to pregnancy, contraception or the termination of a pregnancy.
- Gender Affirming Care → Dates of Service: _____ ☐ YES ☐ NO Initials: _____
- Sexually Transmitted Disease → Dates of Service: _____ ☐ YES ☐ NO Initials: _____
- HIV Testing and Results → Dates of Service: _____ ☐ YES ☐ NO Initials: _____
- Alcohol, Drug, or Substance Abuse → Dates of Service: _____ ☐ YES ☐ NO Initials: _____
- Mental Health/Psych Records → Dates of Service: _____ ☐ YES ☐ NO Initials: _____
- Genetic Testing Records → Dates of Service: _____ ☐ YES ☐ NO Initials: _____

The purpose of this disclosure or use is for the following reason: (Optional): ☐ Medical ☐ Legal ☐ Disability

☐ Insurance ☐ At the request of the patient ☐ Other: _____

Middlesex Health

Authorization to Release or Obtain Information

By signing this authorization form:

- I understand that Middlesex Health will not condition treatment, payment, enrollment or eligibility for benefits based on my signing this Authorization. I acknowledge that I am signing this Authorization freely, and no one has coerced or pressured me to sign the Authorization.
- I understand that I may revoke this Authorization at any time by providing written notice to:

  Director, Health Information Management
  Middlesex Health
  28 Crescent Street
  Middletown, CT 06457
- I understand that the revocation will not apply to information that has already been released in response to this Authorization.
- I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- **I understand that if the Protected Health Information (medical record information) that is disclosed under this Authorization is confidential HIV/AIDS related information or alcohol or drug abuse related information, the recipient may not re-disclose that information under Connecticut State Law and Federal Law.**
- **I understand that Protected Health Information (medical record information) released per this authorization may no longer be protected by state law or the federal health privacy law and could be redisclosed by the person or entity that receives it.**
- **I understand that MyChart contains only selected portions of my medical record and is NOT my complete official legal medical record.**

Method of Disclosure:

☐ MyChart ☐ Mail ☐ Electronic (Patient Portal) ☐ Email *By choosing email, I understand that standard email services such as g-mail and other private email providers are not secure or encrypted. This means that email messages can be intercepted. Despite these risks, I understand the risks involved and would like my medical records sent via the following email address: _____

Unless otherwise revoked, this Authorization will expire on the following date, event or condition: _____
If I fail to specify an expiration date, event or condition, this Authorization will expire one year from the date signed below.

Return completed authorization by mail, fax or email as designated below:
Mailing Address: Middlesex Health
Health Information Management
Release of Information Unit
28 Crescent Street
Middletown, CT 06457
Fax Number: 860-358-6366
Email Address: Release_of_Information@midhosp.org

_____ _____
Signature of Patient/Patient Representative **Date**

Relationship to Patient: ☐ Self ☐ Parent ☐ Guardian ☐ Conservator ☐ Power of Attorney ☐ Administrator/Executor of Estate ☐ Documented Next of Kin

If signed by the legal representative, attach appropriate documentation to verify.

Complete the section below only if the person requesting records is not the patient but a Legal Authority (*e.g.* conservator, health care representative, power of attorney, executor of the estate).

Verification of Legal Authority	Name of Legal Authority	Relationship to Patient
Representative's Address & Tel. Phone #	**Verification of Identity** (Internal use only)	**Verification of Authority** (Internal use only)

NOTICE

Psychiatric Records and Communications

In the event that information released constitutes privileged psychiatrist-patient communications:

> "The confidentiality of this record is required under chapter 899 of Connecticut General Statutes. This material shall not be transmitted to anyone without the written consent or other authorization as provided in the aforementioned statutes." (§ 52-146i)

Drugs and Alcohol Abuse Records

In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records regulations:

> "This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65."

HIV Related Information

In the event that information released constitutes confidential HIV related information protected under Connecticut Law:

> "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 law. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose." Conn. Gen. Stat. 19a-585(a)

Reproductive Health

In the event that information released constitutes reproductive health care services information protected under Connecticut Law:

> "This information has been disclosed to you from records whose confidentiality may be protected by state law. A patient, or the patient's conservator, guardian, or other authorized representative has the right to withhold written consent to release this information, unless the law permits the release of reproductive health care services information without written consent, such as:
>
> (1) pursuant to Connecticut law or the rules of court prescribed by the Connecticut Judicial Branch;
>
> (2) to a covered entity's attorney or insurer for use in the defense of an action or proceeding;
>
> (3) to the Commissioner of Public Health in connection with the investigation of a complaint, if such records are related to the complaint, or
>
> (4) if child abuse, abuse of an elderly individual, abuse of an individual who is physically disabled or incompetent or abuse of an individual with intellectual disability is known or in good faith suspected."