Middlesex Health Primary Care

FORM 1

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Name of Patient:	DOB:

I hereby authorize Middlesex Health Primary Care to release/obtain all medical information with respect to the treatment of the above referenced patient, including information relating to diagnosis or treatment of mental illness or drug or alcohol abuse and /or confidential HIV related information.

Release the Medical Records From:

Method: ☐ Mail ☐ Pick up ☐ Fax

Medical Group Name:_____

Address: _____

City: _____State: _____ Zip:_____

Fax: (If needed):_____

Phone: _____

Send the Medical Records To:

Method: ☐ Mail ☐ Pick up ☐ Fax

Name: Middlesex Health Primary Care

Address: _____

City: _____State: _____ Zip:_____

Fax: (If needed): 860-358-8659

Phone: _____

What is the Purpose of Health Information Release?

☐ Personal	☐ New Physician	☐ Social Security Disability	☐ Other: _____
☐ Primary Care Physician	☐ Medical Ins. Claim	☐ Life Insurance	
☐ Consultation	☐ Worker's Comp	☐ Attorney	

Describe the Health Information to be released:

Service Dates: from:_____to:_____Information Needed By: _____

☐ Complete Medical Record	☐ Other: _____		
☐ History and Physical	☐ EKG's	☐ Laboratory Results	☐ Hospital Notes
☐ Immunization Records	☐ Pathology Reports	☐ Radiology Reports	☐ Clinic Notes
☐ Hospital Discharge Summary	☐ Operative Reports	☐ Radiology Images	☐ Billing Information

I understand that Middlesex Health Primary Care 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 Middlesex Health Primary Care. I understand that I may not be able to revoke this Authorization if Middlesex Hospital Primary Care has taken action in reliance on the Authorization, or if the Authorization was obtained as a condition of obtaining insurance coverage.

I understand that the Protected Health Information disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by the Federal Privacy Regulations.

I also understand that if the Protected Health 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.

This Authorization will expire one year from the date of signing unless I indicate an earlier date or event here:_____

Date: **Signature of Patient or Person granting Authorization on behalf of patient**

Printed Name of Person Signing (If Not the Patient) **Relationship to Patient**