Patient Authorization For Use or Disclosure of Protected Health Information

Medical Records Release/ Request Form

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Connecticut law, this practice may not use or disclose your individually identifiable health information without your authorization except as provided in our Notice of Privacy Practices. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purposes for the disclosure.

☐ Release of Medical Records ☐ Request for Medical Records

I hereby authorize this medical practice, _____
(name of practice)
to release health information of patient named below:

Patient Name: _____ Date of Birth: _____
(Print)

AKA (Other names): _____

Dates of Service to Release: _____ OR ☐ Entire Medical Record

Reason for Release: _____

(Reason for release **must** be noted on this form.)

Please Print: Send medical records to:

Name of Physician or Practice: **OB/GYN of Fairfield County**

Address of Physician or Practice: **1735 Post Road**

Fairfield, CT 06824

Restrictions: I understand that the recipient of this information may not use or disclose this information except for the expressed purposes identified above, unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.
I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

Exclusion (please initial): Drug/Alcohol _____, Mental Health/Psychiatric _____,
Sexually Transmitted Disease ____, HIV/AIDS ____, Other ____, description of other exclusion: _____

Refusal to Sign Authorization
I understand that my health care treatment or benefits will not be affected whether I sign or do not sign this form.

I understand that I may revoke this authorization at any time by notifying this medical practice in writing as described in the Notice of Privacy Practices. My revocation will not affect actions taken by this medical practice prior to its receipt.

I understand that, if the recipient of the information is not a health care provider or health plan covered by HIPAA, the information used or disclosed as described above may be redisclosed by the recipient and no longer protected by HIPAA. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.

I understand that I have the right to receive a copy of this authorization.

This authorization is effective this date: _____ thru _____

Signed: _____ Print Name _____ Date: _____

(Please check appropriate box)

I am the ☐ Patient ☐ Guardian ☐ Conservator ☐ Patient's Representative

(Please print name and address below.)

Name: _____ Address: _____