Authorization to Disclose Medical Record Information

Please send completed form to:
ProHealth Physicians, ATTN: Medical Records, 3 Farm Glen Blvd, Farmington, CT 06032

Patient Information

Patient's Name: ______________________________

Patient's Address: ______________________________ D.O.B: ______________

City: ______________ State: ________ Zip: __________ Phone #: ( ) ______________

Release Information

I authorize ProHealth Physicians to: ☐ **Send my medical records to:** ☐ **Request my medical records from:**

Name/Facility: ______________________________ Attention: ______________

Address: ______________________________ Phone: ______________

City: ______________ State: ________ Zip: __________ Fax: ______________

Purpose of Request: ☐ Personal ☐ Continued Care (Appt. with Specialist) ☐ Legal ☐ Insurance
☐ Transfer of care (New Physician) ☐ Other: ______________________________

Information to be Released

**Please specify date ranges.*

☐ Abstract (*Generally recommended for transfer of care. It includes 2 years of notes and labs and 5 years of diagnostics.)

☐ Office Visits *_____ to ____ Specify Provider(s): ______________________________

☐ Lab Results: *____ to ____ ☐ Radiology/Imaging Reports: *_______ to ________

(If radiology **images**, please contact the radiology department directly: (1-877-643-8759)

☐ Other *(please be specific)*: ______________________________

Legally Protected Information

The following items will not be included, unless specifically authorized.

☐ Genetic Testing Initial: ________

☐ HIV/AIDS Results Initial: ________

☐ Sexually Transmitted Diseases Initial: _______

☐ Psychiatric Health (Include Behavioral Medicine Notes) Initial: _______

☐ Substance Use Disorder Care *(42 CFR Part 2Records)* Initial: _______

☐ Reproductive Health Care Services Initial: _______

Fees & Format

We may charge a fee for asking and sending copies (HIPAA 45CFR, 164.524). For many patients, an Abstract (2 years of notes and labs and 5 years of diagnostics) is enough for their care. For a complete record or more than 3 years of notes, the rate may go up due to cost. At no time will the cost-based fees exceed Connecticut law (Section 20-7c of the CT General Statutes).

Preferred format for release *(file size restrictions may apply)*

☐ Paper. ☐ Fax ☐ Patient Portal

- *I understand I can cancel this authorization at any time. I must give a written statement to ProHealth Physicians to cancel. Canceling won't affect information already shared with consent. I understand this authorization is good for 12 months, unless noted or canceled. Please note an expiration date if less than 12 months:___/___/___.*
- *I understand that granting the release of this health information is not required. I do not need to sign this form to get care.*
- *I understand that my health record may have details on my mental health, substance abuse disorders or otherwise sensitive information. Releasing information may lead to unauthorized re-release. Which may not be protected by federal confidentiality rules.*

Signatures

Patient/Legal Representative* Signature: ______________________ Date: ______________

Print Name of Legal Representative: ______________________ Relationship to Patient: ______________

**You must show proof that you're an authorized representative with access to members'/patients' records. Include the signed authorization with this request.*

This authorization must be completed in its entirety or it will not be processed.