ProHealth PHYSICIANS

AUTHORIZATION TO REVIEW OR OBTAIN COPIES OF MEDICAL RECORDS

I, _____ (print name), authorize _____to release the medical records of

_____ (print name of patient), _____ (patient's DOB).

The records should be sent to:

ProHealth Physicians

Recipient Name | Street Address | City, State, ZIP Code

(Note: there is a 65 cent per page copying charge generally allowable under Connecticut State Law)

INFORMATION TO RELEASE

I request that the information to be used or disclosed consist of the following (*if this is an authorization for the use or disclosure of psychotherapy notes, it may not be combined with an authorization for the use and disclosure of any other type of health information)*. **CHECK ALL THAT APPLY**:

☐ Complete Medical Record (including records from prior providers) ☐ Only Medical Record from ProHealth Providers

☐Medical History, Evaluation Records	☐ X-ray Reports	☐Laboratory Reports
☐ Hospital Records Including Reports	☐ Immunizations	☐ Prescription Data
☐ Consultation Documentation	☐ Surgical Reports	☐Summary of Record

☐ Other (Specify):_____

□ Sensitive information regarding HIV/AIDS, or treatment for substance abuse (alcoholism or drug abuse) and/or mental health issues may be disclosed.

□ I do not authorize the release of sensitive information regarding HIV/AIDS, or treatment for substance abuse and/or mental health.

PURPOSE OF USE/DISCLOSURE

It is my understanding that the information to be used or disclosed will be used for the following purposes (**CHECK ALL THAT APPLY**): ☐ At the request of the individual signing this authorization (no purpose need be specified)

☐ Additional Medical Care ☐ Change of Provider ☐ Insurance Eligibility/Benefits ☐ Legal Investigation or Action

☐ Other (Specify): _____

REDISCLOSURE: I understand that the disclosed information may be redisclosed in accordance with law and may no longer be protected by privacy requirements. Further, I understand that if the authorized recipient is not a provider, health plan, or clearinghouse required to comply with federal privacy standards, the information disclosed pursuant to this authorization may no longer be protected. However, other state or federal law may prohibit the recipient from disclosing specially protected information, e.g., substance abuse treatment information, HIV/AIDS-related information, and mental health information.

INDIVIDUAL'S RIGHTS: I understand that I must be provided with a copy of this form if I choose to sign it. I understand that I am under no obligation to sign this form and that ProHealth Physicians may not condition treatment, payment, or enrollment/eligibility for benefits on my decision to sign this form. I understand that I may revoke this Authorization by notifying ProHealth Physicians in writing of my revocation. To revoke or to receive a copy of my revocation, contact ProHealth Physicians' Privacy Official, 3 Farm Glen Boulevard, Farmington, CT 06032, Attn: Privacy Official. I am aware that my revocation will not be effective until received by ProHealth and will not affect uses and/or disclosures prior to its receipt.

ALTERATION: This authorization may not be altered in any manner. If altered, in the sole discretion of ProHealth it may be considered void and of no effect.

EXPIRATION DATE: This Authorization is valid for **one year** from the date signed unless otherwise specified here: _____.

SIGNATURE:

_____

CIRCLE ONE: PATIENT / PARENT / HEALTH CARE REPRESENTATIVE / EXECUTOR / ADMINISTRATOR*

_____

PRINTED NAME

_____

DATE

*Attach copy of appointment as health care representative/executor/administrator

Revised June 2016