

## **REQUEST TO ACCESS PROTECTED HEALTH INFORMATION**

**You may keep this page for your records.**

**The attached form may be used to request access to your medical records. We are required to allow you to access your health information unless federal law specifically permits denial.**

**We typically respond to requests for access within 30 days of receiving them. You may expect to receive a response or a notification of delay within that approximate time frame.**

**If you are requesting photocopies of your records for your personal use, you will be notified of charges (\$.65 per page, plus shipping, in accordance with CT regulations) and will be billed prior to shipping. Our copying service will notify you of any such charges.**

**For more information about accessing a medical or billing record, you may contact our Correspondence Secretary, at 576-5193. Please note, however, that requests for access must be made in writing and will not be accepted by the Correspondence Secretary at this number.**

**To submit a request for access, please complete, sign and return the attached form to:**

**Correspondence Secretary  
Health Information Services Department  
St. Vincent's Medical Center  
2800 Main Street  
Bridgeport, CT 06606**

**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

<b>Print Patient Name:</b> _____	<b>Date of Birth</b> _____
<b>I authorize St. Vincent's Medical Center, 2800 Main Street Bridgeport, CT 06606, to disclose health information of the above named individual as described below.</b>	
<b>The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)</b>	
<input type="checkbox"/> Most recent discharge summary	<input type="checkbox"/> Most recent history and physical
<input type="checkbox"/> Operative/ procedure report from (date) _____ to (date) _____	<input type="checkbox"/> Emergency Department record from (date) _____ to (date) _____
<input type="checkbox"/> Laboratory results from (date) _____ to (date) _____	<input type="checkbox"/> X-ray and imaging <b>reports</b> <b>films</b> (circle appropriately) from (date) _____ to (date) _____
<input type="checkbox"/> Consultation reports by (Doctor's name) _____ _____ _____	<input type="checkbox"/> Entire record <input type="checkbox"/> Billing record (forward to Patient Financial Services) <input type="checkbox"/> Other (please specify) _____ _____

**I understand** 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/or drug abuse.

<b>This information may be disclosed to and used by the following individual or organization:</b>	
Name: _____	Address: _____
For the purpose of: <input type="checkbox"/> Medical <input type="checkbox"/> Legal <input type="checkbox"/> Disability <input type="checkbox"/> Insurance <input type="checkbox"/> At request of patient or legal representative	
<input type="checkbox"/> Other (please specify) _____	

**I understand** that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Services Department. 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. Unless otherwise revoked, this authorization will expire in 90 days or on the following date, event or condition:

\_\_\_\_\_  
(list specific event, date or condition)

**I understand** that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or have copies made of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Services Department.

\_\_\_\_\_  
Signature of Patient or Authorized Representative      Date: \_\_\_\_\_

Relationship to Patient if not signed by patient: \_\_\_\_\_

Reason for signature other than patient: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_      Date: \_\_\_\_\_