

AUTHORIZATION TO RELEASE / DISCLOSE PROTECTED HEALTH INFORMATION

<p>For Internal Use Only: MRN: _____ FIN: _____</p>

Patient Name: _____
(Last) (First) (Middle Initial) (Maiden/Other Name)

Date of Birth: _____ Phone: _____

Complete Address (street or box#, city, state, zip)

This information is to be used for purpose of: Self Medical Care Attorney Disability Workers Comp
 Insurance Eligibility/Benefits Other _____

I hereby authorize St. Vincent's entity(ies) named below to release information from my medical record to:

Name: _____

Address: _____ City/State: _____ Zip Code: _____

Method of Disclosure:

Mail Pick Up (Photo ID Required) Secure electronic medium (if applicable, thumb drive or secure email: _____)

Please indicate records you are requesting by checking boxes below:

St. Vincent's Medical Center St. Vincent's - Westport Campus Family Health Center Wound Care Center
 Outpatient Behavioral Health: () Norwalk () Bridgeport
 Urgent Care Center: () Bridgeport () Shelton () Monroe () Fairfield () Milford () Stratford () Trumbull
() Other: _____

Multispecialty Group: Physician Name: _____

Release Content: Date(s) of service requested: From: _____ To: _____

- | | |
|-------------------------------------------------------------|----------------------------------------------------------------------------|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Radiology reports |
| <input type="checkbox"/> History & physical examination | <input type="checkbox"/> Inpatient record, including Psychiatric Inpatient |
| <input type="checkbox"/> Consultation reports | <input type="checkbox"/> Laboratory tests |
| <input type="checkbox"/> Emergency Dept. record | <input type="checkbox"/> Pathology slides |
| <input type="checkbox"/> Rehabilitation Dept. notes | <input type="checkbox"/> Outpatient |
| <input type="checkbox"/> Outpatient Behavioral Health notes | <input type="checkbox"/> Entire record |
| <input type="checkbox"/> Radiology films/images | |
| <input type="checkbox"/> Other (please specify): _____ | |



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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 (Any records containing any of this information requires signature from age 13 and older to sign release of records).

Please do not release the following information: _____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must 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 365 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. I understand that there is a charge for copies in accordance with Connecticut law.

 Signature of Patient or Authorized Representative Date _____

Relationship to Patient if not signed by patient: _____

Reason for signature other than patient: _____

Must provide proof of authority (except parent of a minor)

Identify Validated by: (St. Vincent's Employee): _____

Verified by: (Form of ID) _____

