Medical Records Request

Connecticut Children's

10 Columbus Blvd, Hartford, CT 06106 • (860) 837-5780 *phone* • (860) 837-5785 *fax*

WWW.CONNECTICUTCHILDRENS.ORG

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize Connecticut Children's and/or Connecticut Children's Specialty Group, Inc. to use and/or disclose my protected health information (PHI) as provided below. I understand that I may revoke this Authorization, but the revocation will not apply to information that has already been released in response to this authorization. The written revocation letter needs to be sent to the Health Information Management (HIM) Department of Connecticut Children's. I understand that my/my child's treatment is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it. I understand that once the PHI listed below is used or disclosed as set forth in this Authorization, it may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations.

STOP **Please note that each section of the form must be completed in its entirety. Failure to complete a section (including dates) may delay the processing of your request. Please print clearly. ** Photo Identification may be requested for signature verification purposes.****

Patient Name _____ Date of Birth _____

Previous Names (if applicable) _____ Phone ( ) _____

Parent/Guardian Completing Form (please print name) _____

Patient Address _____

City _____ State _____ Zip Code _____

FOR CONNECTICUT CHILDREN'S TO ***DISCLOSE*** RECORDS **(OR)**	FOR CONNECTICUT CHILDREN'S TO ***OBTAIN*** RECORDS
I authorize Connecticut Children's to disclose health information to: Name: _____ Facility: _____ Address: _____ City, State, Zip: _____ Telephone: _____ Fax: _____	I authorize _____ to disclose health information to: Dept./Physician: _____ Connecticut Children's 282 Washington Street Hartford, CT 06106 Contact Person: _____ Telephone: _____ Fax: _____
Method of Disclosure ☐ Mail ☐ Pick-Up ☐ MyChart (if available) ☐ Fax (Healthcare Facilities/Providers **ONLY**)	

The dates of service and the types of information to be used or disclosed are as follows: **Date(s) of Service/Department Requested:** _____

☐ History & Physical ☐ Discharge Summary ☐ ED Record ☐ Procedure/Operative Reports ☐ Immunizations

☐ Laboratory Reports ☐ Radiology Reports ☐ Radiology Images ☐ PT/OT/ Speech Audiology Notes ☐ Progress Notes

☐ Billing records ☐ Pathology Reports ☐ Entire Record ☐ Other _____

The purpose of this disclosure or use is:

☐ Medical ☐ Legal ☐ Disability ☐ Insurance ☐ School ☐ At the request of patient ☐ Other: _____

If records are needed for an UPCOMING appointment, please specify date of appointment: _____

STOP ***I understand that state law prohibits use and/or disclosure of the PHI listed below unless specifically authorized by me. I understand that such information will not be used or disclosed in response to the above request unless I indicate my authorization by initialing below.***

Mental Health/Psychiatric: *(initials)* _____

HIV Tests & Related Information: *(initials)* _____

Alcohol and/or Substance Abuse *(initials)* _____

EXPIRATION DATE: Unless I revoke this Authorization or provide a different expiration date below, this Authorization will expire twelve (12) months from the date of execution. Other Expiration Date (may not exceed 12 months): _____

Signature: _____ Date: _____

Check One: ☐ **Patient** ☐ **Parent** ☐ **Legal Guardian**

***Note:** If Legal Guardian box is checked, documentation establishing guardianship must be provided or on record in order to comply with the above request.*

PC 18-367 New 4/2018: Revised 112018, 1/2019 , 6/2019