# RELEASE OF INFORMATION

Patient Full Name: _____ Previous Names (if applicable) _____

Patient Address: _____ Date of Birth: _____

City: _____ State: _____ Zip Code: _____ Phone #: _____

I authorize any member of the medical staff of Connecticut Children's Medical Center and/or Connecticut Children's Specialty Group or any of its employees or representatives to use and/or disclose my protected health information (PHI) as provided below. I understand that I may revoke this Authorization, except to the extent that the entity has already taken action in reliance on this Authorization. The written revocation letter needs to be sent to the Health Information Management (HIM) Department of Connecticut Children's Medical Center. The provision of treatment will not be conditioned on the completion of this Authorization. I understand that once the PHI listed below is used or disclosed as set forth in this Authorization, such information is subject to re-disclosure and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that a fee may be charged for this service and that prepayment may be required.

## INFORMATION TO BE USED BY/DISCLOSED FROM:

(Check the appropriate box(es))

❑ Connecticut Children's Medical Center ❑Connecticut Children's Specialty Group ❑ Other

## INFORMATION TO BE USED BY/DISCLOSED TO:

Provider Name/ Organization: _____

Address:_____

City, State, Zip:_____

Phone #:_____ Fax # _____

## PURPOSE OF USE/DISCLOSURE:

❑ At request of patient ❑ Other _____

## INFORMATION TO BE USED/DISCLOSED:

❑ Complete Medical Record **Date(s) of Service:** _____

❑ Inpatient Medical Record **Date(s) of Service:** _____

❑ Outpatient Medical Record **Department(s):** _____**Date(s) of Service:** _____

❑ Other: _____ **Date(s) of Service:** _____

I understand that state law prohibits the 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 unless I indicate 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:

_____

**SIGNATURE:** If the patient is unable to sign, please indicate the authority of the person who is signing for the patient.

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| Date | Signature of patient/representative | Print name | Relationship to patient |

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