Patient Authorization for Use or Disclosure of Protected Health Information

Women's Obstetrics And Gynecology, P.C.
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Trumbull, CT 06611

Medical Records Release/Request Form

As requested by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Connecticut law, this practice may not use or disclose your individually identifiable health information without your authorization except as provided in our Notice of Privacy Practices. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purposes for the disclosure.

Release of Medical Records Request for Medical Records

I hereby authorize my medical record to be released from:_____for the patient named below:
(Name of Doctor)

Patient Name:_____ Date of Birth_____
(Please Print)

Reason for Release/Request _____
(Reason for Release/Request MUST be noted on this form)

Please Print – Send records to:
Name of Physician or Practice:

Restrictions: I understand that the recipient of this information may not use or disclose this information except for the expressed purposes identified above, unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

I understand that 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 drug abuse.

Exclusion (Please Initial): Drug/Alcohol_____ Mental Health/Psychiatric_____ Sexually Transmitted Disease_____

HIV/AIDS_____ Other_____Description of other exclusion_____

_____

Please circle appropriate selection:

I am the: Patient Guardian Conservator Patients Representative

Name:_____
(Please Print)

_____ _____
(Signature) Date

The cost to send/fax medical records is $0.65/page plus shipping and handling

HIPAA Compliant Patient Authorization